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ABSTRACT

Four issues of the newsletter of the Hill Top Preparatory School (Rosemont, Pennsylvania) which provides secondary educational services to learning-disabled adolescents are presented. Issues typically have one or two major articles. Article titles and authors are as follows: "The Parents of Exceptional Children: What Helps Them Cope with Situations; Review of the Literature" (Robert Naseef); "LD Specialist Describes Program for Students at Community College" (Kathy Lowe); "Vocational Rehabilitation Services Open for Learning Disabled Adults" (Esther Minskoff); "Role of Rehabilitation Counselors Key to VR Planning for LD Adults" (David Gragan); "Learning Disabled Adolescent Viewed at Risk for Drug and Alcohol Abuse" (Benson Gever); "M.D. Discusses Assessment, Treatment of Depression, Suicidal Tendencies in Children with Learning Disabilities" (G. Pirooz Sholevar); "Attorney Details Efforts to Break LD and Juvenile Delinquency Link" (Felicity Lavelle); and "Sexuality Presents Special Problems for Learning Disabled Adolescents" (Elissa Fisher and Andrea Fina). (DB)

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Review of the Literature

The Parents of Exceptional Children: What Helps Them Cope with Situation

Robert Naseef, M.A.

All parents have a dream for their children - an image of who their child will be and what he or she may accomplish in life. When a child is impaired by a physical, sensory or mental handicap, that dream is shattered and lost, and the parents are faced with having to accept a child who will never be able to live up to their expectations. Furthermore, family life is afflicted by the chronic stress of coping with the day-to-day needs of an exceptional member.

Over the past three or four decades, aided by the advent of Public Law 94-142, there has been a proliferation of educational and mental health services for these special needs children in order to help them develop to their fullest potential. Parents are no longer immediately counseled after the diagnosis or discovery of the handicaps to institutionalize their children or send them to boarding schools. Instead, parents are expected to work along with professionals to provide an education in the "least restrictive environment", i.e. around normal children as much as possible and within the context of growing up in the family.

Nonetheless, the goal of the "parent-professional partnership" to raise exceptional children to their greatest potential remains an elusive goal. Parents are challenged to participate as teachers and therapists for their children, but the issue of who takes care of the parents is frequently overlooked. The medical, social service, educational, and mental health systems are focused primarily on the child while the parents are expected to somehow meet the challenge of daily living with an impaired child. In addition, the impact on siblings is rarely, if ever, dealt with even though they are a vital part of daily life for the whole family as well as the exceptional child.

Doing everything possible, maintaining hope, fighting off despair, and living as normal a life as possible is the dilemma faced by the parents of special children. Although it is difficult, many parents do report being able to live relatively normal, happy, and fulfilling lives. Finding out what helps parents to adapt and cope is an area requiring continuing research.

Theoretical Overview

Mourning

Children can be born with or develop one or more of a vast array of disabling conditions. Brewer and Kakalik (1979) estimate that the number of disabled children and youth may be as high as 12 percent of the population. As many clinicians and researchers have reported, the family is confronted by an emotional crisis and many practical problems in caring for a special needs child. Finding the resources to solve these problems is difficult but not impossible. Unfortunately, early practice in this area was based primarily upon clinical observations of parents with an impaired child, and parents were frequently seen as neurotic and as part of the child's problem. The impact of the child upon the parents and the reciprocal nature of the interaction was not generally considered.

Although people choose to have children for different reasons, most couples look forward to having children as the culmination and fulfillment of their marriage. Solnit and Stark (1961) from a psychoanalytic frame of reference recognized parents' reactions to the birth of a defective child as a mourning for the loss of the longed-for healthy child. This loss is similar to the loss of a loved person, a valued possession, a job, an ideal, a body part, etc. The mourning for the loss of the ideal child is theorized to be experienced as repetitions of previous losses. The feelings experienced are loss, intense longing for the hoped-for healthy child, resentment, and guilt. The mourning process is complicated because the child has lived and there is an unrelenting daily impact on the parents, particularly on the mother as the caretaker.

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Solnit and Stark used the theory of the mourning process together with their clinical observations in order to understand and help alleviate the depressed reactions of certain mothers to the birth of their handicapped children. They further extended this insight to explain the depressed reaction of some mothers to the birth of a normal child when the mother feels a loss because of her wished-for image of the child and the actual normal child which she has given birth to.

Helping professionals frequently belabor what they see as the tendency for parents to deny the reality of their child's handicap. Olshanky (1962) points out how parents' chronic sorrow is frequently interpreted as a neurotic manifestation rather than as a normal response to a tragic situation. Professionals' interpretation of parents' behavior could be very different indeed if chronic sorrow as the child and the family progress through the life cycle were to be seen as a natural, rather than a neurotic, response. Mandelbaum and Wheeler (1960) observed parents' rebellion and their conscious effort to make sense out of the senseless and concluded that these behaviors are not always efforts to deny reality. Instead, this resistance and rebellion might actually be healthy adaptive mechanisms that can lead to successful adaptation and coping on a daily basis.

Mourning Stages

On the basis of her work with dying patients and their families, Elizabeth Kubler-Ross (1969) identified five stages that occur in the normal grieving process: denial, anger, bargaining, depression, and acceptance. Movement through these stages is rarely seen as smooth. There may be regression to a previous stage, or a grieving person may become fixated or stuck at a particular stage. There have been several attempts to establish a model of the grieving stages as they apply to parents after the birth or diagnosis of a handicapped child.

Fortier and Wanlass (1984) reviewed the available literature on this mourning stages as applied to the parents of handicapped children and formulated a theory based on a combination of their own observations and the literature. The number, name, and sequence of the stages vary, but the end result is always theorized to be the acceptance of the child. The model proposed by Fortier and Wanlass will be summarized here because it represents a synthesis of much of the available literature from over

two decades, and their model is representative of the many models in the literature.

The first stage is called "impact" and begins when parents either suspect that their child is defective or are informed of their child's handicap. In the case of blindness or physical deformity the parents may be told at birth, while an awareness of the handicap may come more slowly as in the case of mental retardation, autism or learning disabilities. In either case parents frequently find themselves in a situation which they are not ready to accept. There is usually anxiety and disorganization in the family. The family is faced with the task of coping and formulating plans for the future.

Most parents seem to experience some form of denial shortly after the diagnosis and this is the second stage. Denial may take the form of refusing to accept the diagnosis. Some parents may even refuse to see a newborn, defective child and choose to institutionalize the child immediately. Others fantasize a miracle cure or refuse to believe that the disability is as severe as they were told. Whatever the specific reaction, denial buys time to allow the family to accept the reality of the situation. Parents do need hope to carry on. The literature on exceptional children is also replete with references to parents who through hard work, hope, and love have helped their child develop far beyond the expected potential.

The grief stage is characterized by feelings of anger, guilt, and sadness. Parents may question "Why me?"; they are frequently angry that they were singled out by fate or blame themselves, the doctor, their spouse, society, and even God. In addition parents may isolate themselves because of the shame and guilt that they feel. Darling (1979) applied the concept of stigma to parents of exceptional children. Parents may avoid others with normal children because of the intense grief and shame that they are experiencing. The intensity and length of the grief reaction varies, but grief is no longer seen as the result of the parents' inability to accept the reality of their child's handicap. Grief is a period of adjustment which some theorists see as time limited and others see as recurring.

Fortier and Wanlass believe that a stage of focusing outward follows the experience of grief. Adequate coping is theorized to begin at this time. At this point, it is possible to make plans for the child's care that are congruent with reality. Parents are able to both trust in themselves and ask for help from others.

The fifth phase or closure is characterized by putting things in order. The crisis is over and the family has developed coping mechanisms. There is a realistic sense of hope that the family can and will survive. There will be other crises but the family has been reconciled to the fact that having a handicapped member will be a part of day-to-day life.

Not all authors agree on the existence of a stepwise mourning reaction or grieving. Moses (1979) believes that grieving is repetitive because the loss is experienced over and over through the development of the child. Grieving is seen as the process whereby an individual separates from a significant lost dream or fantasy or projection into the future. It is furthermore the feeling process whereby an individual lets go of old shattered dreams and is able to formulate new, more attainable dreams. Moses identifies grieving states of denial, anxiety, fear, guilt, depression, and anger. Each of these states serves the function of bringing the individual's feelings, thoughts, actions, and belief into congruence with the reality of parenting an impaired child. There is, according to Moses, no prescribed order to the process. Grieving, is, however, a prerequisite to coping.

Regardless of whether one believes there is a stepwise progression, there are various points in the life-cycle of the family when parents experience intense stress. Mori (1983) identifies these points:

- the child is born with or the parents suspect a handicapping condition
- the diagnosis is made and treatment is begun
- the child is ready to enter school
- the child reaches puberty
- the child reaches the age of vocational planning
- the parents grow old and worry about who will take care of the child when they die

Living with and raising a handicapped child is not something that one merely accepts once and gets it over with. There is, regardless of one's theoretical

persuasion, a profound impact on daily life that extends through the life cycle of the entire family - mother, father, and siblings.

It should be noted that all parents do not react in the same ways. Some of the variables generally cited in the literature are the nature and severity of the child's handicap, the social acceptability of the handicap, the socioeconomic level of the family, the manner in which the parents are informed, and the age of onset or the age of the child when the diagnosis is made. All of these factors should be taken into account on an individual basis in terms of understanding parents' reactions.

The Family Context

Both research and practice in early childhood development have brought together special education and developmental psychology in new ways. Psychological inquiry and intervention has in the past been focused on questions related to a child's intelligence and potential for achievement. Gradually there has been a shift or a widening of focus to include the social and emotional areas.

This shift has occurred, according to Wright, Granger, and Sameroff (1984), because of the recognition that the child's social and emotional condition provides both the support and the content of most early learning. This broader focus has led to looking at the social and emotional life of the family because education in the first years of life has been almost exclusively in the family context for all children.

The tendency to look at the child's first social context, the family, leads to the notion that the nature of the child has an impact on the family's attitudes and behaviors towards the child. Although parents differ dramatically in their reaction to having a child with a handicap, very little of the variance in reaction is directly related to the severity of the handicap (Wright, Granger, and Sameroff, 1984). There are many variables involved, but the research has generally been limited to the mother-child dyad. This has been true of psychological literature in general and not just the literature on exceptional children.

Fathers of Exceptional Children

Fathers of handicapped children have been infrequently studied according to Seligman (1985). Lamb (1983) notes that until about a decade ago paternal influences on child development were largely ignored. In emphasizing the undeniable importance of mothers, theorists tended to lose sight of the broader social context in which children are raised. It is for this reason that the literature about the fathers of exceptional children is extremely limited.

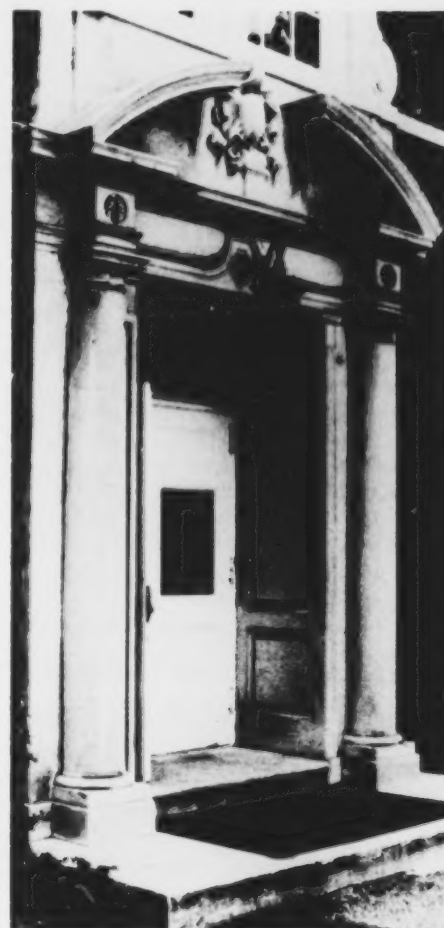
Lamb found a consensus in the literature that mothers and fathers initially respond differently to the impact of an impaired child. Fathers tend to respond less emotionally and to focus more on long-term problems such as the financial burden while mothers respond more emotionally and are primarily concerned with the burdens of child-care. Since fathers are generally more concerned about the social status and occupational success of their offspring, fathers tend to be concerned about the long-term prospects for a handicapped child. Nonetheless, both parents are reported to go through a similar set of reactions involving grief, anger, denial, and guilt (Price-Bonham and Addison, 1978).

McNeil and Chabassol (1984) observed that fathers are looked upon as secondary figures in the treatment and programming of special needs children and that the word "parent" has been synonymous with the word "mother" in the literature. Nash (1965) pointed out that at most child guidance clinics fathers are not involved and professionals assume that fathers do not wish to be involved. The study of 20 sets of parents of hearing-impaired children conducted by McNeil and Chabassol indicated that the mother's involvement is different from the father's. Both mothers and fathers perceived that fathers were concerned and involved with "important issues" relating to the child.

Cummings (1966) studied the effects of the child's deficiency on the mother and later in 1976 studied the effects on the father and noted reduced self-esteem in both mothers and fathers of mentally retarded children. The fathers were especially concerned that the birth of a retarded child proved that they

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were failures as fathers in a biological sense. Cummings theorized that this might be true because fathers have fewer opportunities than mothers to do things with and for their children and therefore have fewer reminders of their value and competence. The tendency of the father to withdraw from the family, according to Lamb, weakens the mother's support system and increases the burden on siblings.

Siblings of Special Children

Until recently siblings of special children have received little notice in the literature. These siblings certainly share in the anticipation and excitement awaiting the birth of a new child. They also share in the grief and pain when their brother or sister turns out to be impaired in some way. Siblings have tremendous insights to share with parents and professionals (Skrtec, Summers, Brotherson, and Turnull, 1984).

The effects of institutionalization for the retarded child upon other members of the family was studied by Caldwell and Guze (1960). Although the researchers found no significant differences between the mothers and siblings of institutionalized and non-institutionalized retarded children, they noted that it was possible to arouse fears of rejection in any child whenever one child is sent away from home. Almost without exception the ideas of the siblings mirrored the family decision - i.e. siblings of the institutional sample felt it was better when the retarded child lived away from home, while siblings of the noninstitutional sample felt that it was better to have the retarded child living at home. The conclusion was made that the type of living arrangement made for a retarded child is not crucial for the adjustment of either the mother or the siblings.

It is now generally believed that the effect of a handicapped child on his or her non-handicapped siblings is largely a function of the parents' attitude and reaction towards the disabled child (Grossman, 1972). Grossman reported in his study that college-age siblings of retarded children found talking with their parents about their siblings' handicaps to be as difficult as talking with them about sex. Wentworth (1974), herself the parent of a special needs child, believes that normal siblings adopt the feelings and behaviors expressed by their parents. As a consequence of how life is influenced by a handicapped sibling, non-handicapped siblings are affected more by their perception of how they are

treated compared to the handicapped sibling than they are by the reality of the condition.

Gargiulo (1985) identified the characteristic reactions of brothers and sisters of exceptional children that were reported in the literature. Normal siblings may resent the handicapped brother or sister because the exceptional child may require a disproportionate amount of parents' attention and resources. Jealousy can result and the non-handicapped child may "act out" to get attention. Anger may lead to fantasies about a harsh action against the handicapped sibling, and the fantasy may result in guilt. There is also the grief over losing a normal sibling to play with and relate to, in addition to the shame and embarrassment that frequently occur when being seen with a handicapped brother or sister in public.

Some siblings, like parents, report benefits from their relationship with an impaired sibling while others report harm. The situation is certainly very complex. Some normal siblings fear that something may be wrong with themselves or feel that they have to work extra hard in school to make up for the deficiencies of their brother or sister and to bring pleasure and satisfaction to their parents. While most available literature indicated that siblings may be at risk for adjustment problems, Simeonson and McHale (1981) noted that siblings of handicapped children are often well-adjusted, mature, and responsible. Normal siblings may also learn to be more accepting of differences and more tolerant of others as a result of growing up with a brother or sister who is different.

How Do Families Cope?

Having provided a theoretical overview and a broader context with which to view the impact of an exceptional child on the family, it is now possible to look at what helps families to cope. Coping is here defined as managing the day-to-day needs of the handicapped child, the other children's needs, and the parents' needs in a realistic manner. It also includes the development of each individual family member in a way that is comfortable and conducive to individual growth.

Clinicians trained to recognize pathology frequently misinterpret parents' attempts to meet these "new tasks and necessities". Based upon their own positive interactions and clinical experiences with families who were successfully meeting these demands, Longo and Bond (1984) challenged the common assumption that dysfunction is the normative pattern in families with an impaired child. They observed families who did not appear to be in crisis or grief stricken but rather absorbed in the daily struggle of meeting the tasks faced. Most studies reviewed by Longo and Bond described and documented problems or concerns that parents of handicapped children face. For example, Cummings, Bagley, and Rie (1966) found that mothers of mentally retarded children were found to have lower self-esteem and higher levels of depression than mothers of normal children.

There is, however, a small but significant and growing body of literature that deals with successful adaption and coping. Friedrich (1979) was interested in the relationship between psychosocial and demographic variables and maternal coping abilities. His findings revealed that marital satisfaction was the most accurate predictor of successful coping and accounted for 79% of the variability in the findings. The mother's security in her relationship with her husband had the most bearing on how capable she felt about coping with her child's handicap.

It has been assumed that the presence of a disabled child has a deleterious effect on the marriage. Divorce rates from three to nine times the national average have appeared in the literature. Longo and Bond, however, found a number of studies in which the quality of the marriage remained stable. Despite the added strain of parenting a child with a chronic disability, many couples were able to keep their marriage intact and reasonably satisfying.

The theoretical constructs of stress, chronic sorrow, mourning and crisis have been helpful in establishing a pattern of normative behavioral reactions that families exhibit at times of loss. The limitation of these theories, however, is that they do not explain the process of adaption which presumes positive coping. Adams and Lindemann (1974) found that coping with long-term disability involved major changes in life style.

Barsch (1968) proposed that parenting can be extremely difficult regardless of the health or disability of the child. He studied the parents of children with a variety of disabling conditions and found that their childrearing practices with handicapped children did not differ significantly from their practices with their normal children. His data led Barsch to conclude that parents, regardless of the health of their child, are more alike than different.

Research substantiating Barsch's conclusions was reported by Busch-Rossnagel, Peters, and Daly (1984). Primiparous mothers with vulnerable infants were compared with primiparous mothers whose infants had no apparent problems. Few significant differences were found between mothers of vulnerable and normal infants. The implication was that during the early months of an infant's life, mothers of vulnerable and normal infants were more alike than different. The differences found by other researchers, such as Cummings et al. (1966) may come later in the mothers' lives according to these researchers.

The psychosocial assets of parents of handicapped and nonhandicapped children were studied by Freidrich and Friedrich (1981). It was hypothesized that significant differences existed, with families including a handicapped child experiencing more stress and less marital satisfaction, psychological well being, social support, and religiosity. One of the few instruments reported in the literature developed specifically for parents of handicapped children, the Questionnaire on Resources and Stress (Holroyd, 1974) was utilized to evaluate parenting problems, problems in family functioning, and problems the parent sees for the child. Parents of handicapped children who were school aged reported more stress and fewer psychosocial assets to help alleviate this continued stress. Increasing social support was recommended as an appropriate intervention.

Venters (1981) studied the families of children with cystic fibrosis. He found two factors which influence the family as a group and might be predictors of successful coping: (1) sharing the burden of the child's illness among the family members, and (2) the family's ability to make some philosophical sense or meaning out of what has happened to them.

Families with and without a handicapped child were studied by Kazak and Marvin (1984) with respect to individual, marital, and parenting stress. They noticed

that previous researchers were well-intentioned in documenting areas of difficulty but sometimes neglected to describe ways in which families might adapt successfully by functioning in a different but not deviant way. Kazak and Martin looked at three structured characteristics of families' support networks (size, density, and boundary density). Four types of support were described: provision of goods and services; providing emotional mastery; offering guidance regarding expectable problems and solutions; and providing feedback on behavior that fosters improved coping and adaption.

Parents of handicapped children were found once again to experience more parenting and personal stress than parents of nonhandicapped children, and the mothers were particularly subject to the stress. In terms of marital stress, the results indicated no significant differences between groups in total marital satisfaction for either mothers or fathers. In terms of social support, the sizes of the support network of the parents of handicapped children were significantly smaller than those of the comparison group. Families of handicapped children had significantly more dense networks, i.e. members of their social networks were more likely to know and interact with each other. Families with handicapped children also had significantly greater boundary density; mothers and fathers had greater overlapping network memberships than in families with nonhandicapped children. Kavak and Marvin conclude from their data that reality for families of handicapped children is far more complex than merely describing high levels of stress that characteristically lead to dysfunction. Adaptational patterns found in this study could be useful in helping families that need help in this area.

Three levels of social support were identified by Schilling, Gulchrist, and Schinke (1984). First comes the nuclear family, close friends and relatives, and other significant persons. The second level includes neighbors, more distant friends and relatives, and some professionals. A third level is still further removed and is found in the context of social institutions. The authors described a structured group approach which they used in their own work to teach parents of handicapped children how to use personal coping and social supports.

According to DeLuca and Salerno (1984), dealing with the long-term stress of living with an impaired child is dependent upon the unique personality characteristics and former coping mechanisms of the family members. The development of particular coping mechanisms is based on:

- how family members normally cope with stress;
- the strategies used to cope with stress directly related to the handicap;
- the extent of additional life stress experienced at a given time;
- the effectiveness of the family's support network.

It is clear that not every stressor, no matter how severe, causes a crisis or dysfunction in the family. Hill (1949) proposed a classic ABCX model of coping with family stress that is applicable to families coping with a handicapped child. In Hill's model whether a particular stressor results in a family crisis (X) depends on characteristics of the stressful event itself and simultaneous related hardships (A) interacting with the crisis meeting resources that the family has (B) and the subjective definition (C) that the family makes of the event.

This model fits the wide range of responses that we see in everyday life in families without a handicapped child or in families with a handicapped child. In the early stages of adjustment, families resort to characteristic ways of dealing with stress. These coping mechanisms run the gamut from alcohol abuse, to emotional withdrawal, to relying on family and friends for support. New coping strategies according to DeLuca and Salerno develop over time with support from other family members, friends, professionals, and particularly through the support of other parents of handicapped children.

Conclusions

This review of the literature finds coping with an exceptional child to be a process rather than an end state. It is, moreover, a process that occurs within the context of family life and within the lifespan of each individual family member including the handicapped child. Even though early research was

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hampered by the tendency to look for pathology instead of solutions, much that was useful has been contributed and has been summarized here.

There is a new trend to look at the exceptional child in context and to look for solutions instead of problems. It is this trend that can help families who live within a society that is committed to providing for the education of handicapped children in "the least restrictive environment". Nothing less is really worthwhile from this perspective.

As Stoneman and Brody (1984) have concluded, relatively few studies have gathered scientific data on the day-to-day lives of families with exceptional children. Since most of the literature has focused on parent-child (usually mother-child) interactions, relatively little is known about the form of family interactions in families with an exceptional child.

Two of the most widely used methods for studying families have been the self-report and observational methodologies. Family members' thoughts, feelings, or perceptions are best studied through self-report, but the literature consistently finds self-report methods inadequate in studying family interactions. Observational methodologies are able to describe the dynamic and fluid nature of family interactions. Stoneman and Brody propose using the interplay of self-report and observational methodologies in order to capture the reciprocal influences of thoughts, feelings, attitudes and behaviors. When self-report is used, the same information should be obtained from mothers, fathers, and siblings, thus allowing the researcher to gather convergent or divergent views. In this way, the views and perceptions of the family as an interactive system can be captured as opposed to the views of one individual.

There is also an increasing amount of scientific evidence that some families cope with their situations much better than has been previously suspected. The study of these successful families from the perspective described in this paper can help other families to cope with and adapt to their special situation.

The contemporary emphasis on the rights of the exceptional child has placed a great responsibility on the shoulders of parents. The professional community is likewise obligated to find out more of what we need to know and thus provide more hope and help for the families of our society's exceptional members.

Robert Naseef is Special Services Coordinator at Peirce Junior College in Philadelphia and a psychotherapist in private practice. He is also a Ph.D. candidate in the psychoeducational program at Temple University and this paper was written in partial fulfillment of his doctoral requirements. Mr. Naseef is the parent of an exceptional child.

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LD Specialist Describes Program for Students at Community College

Kathy Lowe, M.Ed.

Brevard Community College in Florida, established in 1960, is a multi-campus college with locations in Cocoa, Melbourne, and Titusville. The Patrick Center and Open Campus classes at locations throughout Brevard County expand the college further into the community enabling it to serve more than 11,500 students annually.

In 1982, approval was obtained from the Auxiliary Learning Aids Fund for the Handicapped for a part-time learning disabilities specialist on the Cocoa campus. As the program grew, grants were written to hire part-time technical assistants, another learning disabilities specialist, a learning disabilities remediation specialist, and a part-time psychologist to provide assistance to learning disabled students on all three campuses: Cocoa, Melbourne, and Titusville. The technical assistants give clerical support as well as tutorial services. The learning disabilities remediation specialist assists with testing and acts as a liaison to all three Brevard campuses. The psychologist administers the WAIS-R for all three campuses. The learning disabilities specialists evaluate test results and coordinate the various facets of the learning disabilities program at the college with both staff and faculty.

The program's philosophy is that college is a realistic goal for many learning disabled students. The staff believes that in order to succeed students need accommodations so that their knowledge is tested, not their disabilities. Experience has indicated that students also need average intelligence (IQ 90 or above) to succeed. The learning disabilities staff interviews students and administers diagnostic tests so appropriate recommendations for each student can be made. The primary accommodations recommended are extra time to complete written tests, recorded textbooks, reduced academic loads, priority registration, individual tutoring in academic areas, study skills, and time management techniques as needed. Assistance in solving social problems is also given when needed since social perception is sometimes a problem with learning disabled students.

Usually a student is referred by an instructor, a program advisor, another student or by him/herself. The student must then complete a learning disabilities test battery if current testing results administered within the last three to three and a half years are not available. This procedure is followed because each public school system or each college from which students come may have its own criteria for learning disabilities eligibility, so the staff must test to see if the student meets the college's established eligibility criteria.

Choosing and using an interpretation of the learning disabilities definition suitable for a college program is necessary. In truth, there is more than one definition available. A common denominator for all is average or above average intelligence but continuous monitoring of available literature on definition and diagnosis must occur for the learning disabilities program to remain abreast in areas of definition interpretation and proper identification.

It was determined that admission to the learning disabilities program at Brevard Community College would be based on the following criteria:

- The student must be enrolled at the college.
- The student must have an average or above average IQ score.
- The student must complete the college's learning disabilities test battery unless documentation of a disability exists based on reliable testing within the past three years.

The test battery used by the college includes:

- Slosson Intelligence Tests
- Wide Range Achievement Test
- Peabody Picture Vocabulary Test
- Shaw Heihle
- Test of Written Language
- Woodcock-Johnson Psychoeducational Test Battery Specific Language Disability Test
- Woodcock Reading Test
- Peabody Individual Achievement Test

- Wechsler Adult Intelligence Scale-Revised.

Other evaluation measures including the Nelson-Denny (math) and GATB (general attitude) may be given by personnel in the learning lab and career lab as an evaluator sees fit.

In addition, input from the student and previous instructors on the student's classroom performance, survey of previous and existing health problems, and a history of academic, social-familial experiences are included in the diagnostic process. This collection of information is then interpreted and applied by the learning disabilities staff to assist in proper evaluation. Once this process is completed, admission to the learning disabilities program is open to all eligible students.

The next stage in the program involves the documentation and follow-up of each student as he/she progresses. One of the ways to do this is by using a tracking instrument. Currently, tracking reports are used to measure the effectiveness of the accommodations or modifications for each student, realizing that not all students need accommodations in all classes.

Among the modifications cited on the tracking reports utilized at Brevard are:

- extra time on tests
- use of calculator
- individual testing in a quiet room
- clarification of directions individually
- accommodation for spelling errors
- needs accurate notetaker
- needs tape recorded texts
- oral testing when possible
- tape recorded lectures
- needs to sit in front of classroom
- clarification of new concepts individually
- accommodation for number reversal.

Prior to using tracking reports, effectiveness was measured by comparing the student's grades before accommodations to those grades after.

Inevitably, an issue which must be mentioned is one which deals with helping learning disabled students match diagnosed strengths with majors and/or careers. Often, a student with a learning disability in math reasoning may want to become an engineer. There is no hard and fast rule about advising in this case. Frequently, a student can be successful in one class and not another, depending on the instructor, or he/she can perform better in a weak subject area if he/she studies more and takes fewer courses each semester. It

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Community College Program

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is easy to say a student should not major in a weak area, but there are many unmeasurable variables such as the student's motivation and persistence. Therefore, advising a student against a specific major would be unfair. Commonly, a student taking a difficult class will audit it first, then take it for credit later. This procedure enables a student to master the material. Sometimes getting through a college curriculum can be harder than functioning on the job. However, no black or white answers are available. Today, all students in Florida colleges must pass communications and math classes. Hard and fast decisions regarding career and major choices may be unfair to the student. Overall, he/she should be given a chance to make his/her own major and career decisions.

A total of 295 students have participated in Brevard's learning disabilities program on all three campuses since its inception in 1982. It has grown from 36 students that first academic year to 100 during 1986-87.

Based on observations made at Brevard, criteria for learning disabled students' "success" in college can vary, but basic criteria seem to be:

- average or above average intelligence
- motivation and persistence

Seventh Annual Hill Top Conference Saturday, October 31, 1987 - Rosemont, PA

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For registration information, contact Tracy Massey at Hill Top, So. Ithan Ave. and Clyde Rd., Rosemont, PA 19010 or call (215) 527-3230.

- maturity level appropriate for age
- good study habits
- reduced academic loads (not taking three heavy reading or writing classes at once) and a two year degree obtained in three years
- individual tutoring
- sufficient ability to compensate for weaknesses
- positive social perceptions
- optimistic attitude
- continuous social or family support.

In summary, college learning disabilities programs must adhere to the philosophy that many learning disabled students can achieve their educational and career goals; federal law insures this right. However, the individual affiliated with these programs must realize that, in most cases, learning disabled students must be twice as persistent in obtaining their degrees. As one learning disabled student at Brevard Community College declared, "Most students climb the educational mountain in a pair of boots. The learning disabled student does it in bare feet."

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Vocational Rehabilitation Services Open for Learning Disabled Adults

Esther H. Minskoff, Ph.D.

Some learning disabled children grow up to be competent, successful adults who no longer need community services. However, there are other learning disabled individuals whose childhood problems continue into adulthood, and who need community services if they are to "make it." Vocational rehabilitation is the major community service available to assist such learning disabled adults.

Prior to 1981, learning disabled persons did not qualify for vocational rehabilitation services because it was the view of governmental rehabilitation agencies that learning disabilities were characterized only by academic problems. In 1981, the Rehabilitation Services Administration accepted specific learning disability as a medically recognizable disability qualifying for vocational rehabilitation services. The definition of learning disabilities adopted by the Rehabilitation Services Administration in 1985 is as follows. "A specific learning disability is a disorder in one or more of the central nervous system processes involved in perceiving, understanding, and/or using concepts through verbal (spoken or written) language or nonverbal means. This disorder manifests itself with a deficit in one or more of the following areas: attention, reasoning, processing, memory, communication, reading, writing, spelling, calculation, coordination, social competence, and emotional maturity." Individuals who manifest these characteristics would be eligible to receive vocational rehabilitation if they satisfy the three following criteria. First, the psychological processing disorder must be diagnosed by a licensed physician and/or licensed or certified psychologist who is skilled in the diagnosis and treatment of such disorders. Secondly, the learning disability must result in a substantial handicap to employment. Finally, there must be reasonable expectation that vocational rehabilitation services may benefit the individual in terms of employment (Rehabilitation Services Administration, 1985).

To broaden the knowledge base concerning learning disabled adults, a number of research projects were federally funded. One of these was the four-year Research and Demonstration Project on Improving Vocational Rehabilitation Services to Adults with Learning Disabilities at Woodrow Wilson Rehabilitation Center. There were five objectives of the Research and Demonstration Project:

1. to identify the needs of learning disabled adults;
2. to identify barriers to vocational rehabilitation and employment of learning disabled adults;
3. to identify factors contributing to successful job placement and job maintenance of learning disabled adults;
4. to develop and evaluate a model diagnostic battery of instruments to identify the weaknesses and strengths of learning disabled adults;
5. to develop and evaluate enhanced treatment programs for learning disabled adults.

The needs of learning disabled adults were determined by surveying the self reported problems of 381 adults who had qualified for vocational rehabilitation services as learning disabled (Hoffmann, Sheldon, Minskoff, Sautter, Steidle, Baker, Bailey, & Echos, 1987). These adults reported significant problems with the academic areas of reading, spelling, and math. They also reported vocationally based problems, such as knowing where to get a job, where to get job training, and how to fill out a job application. Twenty-four percent reported psychological adjustment problems and 16% reported that these adjustment problems were significant enough to make it difficult for them to get or keep a job. These psychological problems may have been due to the difficulties experienced once they left school. Most persons surveyed had not received career education or vocational training in school and were not equipped to enter the world of work. In a study comparing the survey results for the learning disabled adults and the same survey with learning disabled high school seniors, it was found that the high schoolers only reported problems in academics (Minskoff, Sautter, Sheldon, Steidle,

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Role of Rehabilitation Counselors Key to VR Planning for LD Adults

David Gragan, M.Ed.

The decision to recognize Specific Learning Disabilities in adults as a vocationally handicapping condition was a milestone in the struggle for rehabilitation services for the learning disabled. The rehabilitation services delivery system now faces significant challenges in identifying and meeting the needs of this diverse disability group.

BACKGROUND

The question of whether learning disabled individuals should be eligible for vocational rehabilitation services in the so-called State-Federal vocational rehabilitation system has long been a controversial issue. Central to the debate are a number of issues about the concept of learning disabilities vis-a-vis the traditional requirements, procedures, and practices of the Rehabilitation Services Administration (RSA).

In the past, RSA has been reluctant to sanction services for learning disabled individuals for a number of reasons, including a lack of consensus on definition as well as concerns about financing, staffing, and servicing large numbers of learning disabled (LD) referrals. Probably the most significant obstacle to eligibility was the emphasis on medical and psychological service delivery models, and the absence of emphasis on the educational model in which the learning disability category typically found itself. Fundamental RSA eligibility criteria described a "handicapped individual" as any person who:

- (a) has a physical or mental disability which for such individual constitutes or results in a substantial handicap to employment;
- (b) can reasonably be expected to benefit in terms of employability from vocational rehabilitation services.

Learning disabled individuals were not eligible for services unless their problem could be documented as a physical or mental disability. The result was that significant numbers of severely disabled adults were precluded from involvement in the extensive State-Federal vocational rehabilitation (VR) system; assistance to learning disabled persons was nonexistent after high school.

Two interrelated events contributed to a climate for change in the controversy over eligibility for learning disabled individuals. First, whereas the field of learning disabilities originally concentrated on the childhood manifestations of the disability, its focus has been broadened in recent years. The field has turned to the concept of life-long learning over the entire range of development. Moreover, after years of identifying learning disabled students in the schools, attention is now being focused on the large number of these persons who have reached adolescent, young adult, and adult ages—each level bearing chronic problems as well as different barriers to be overcome. (Gerber, 1981).

Secondly, the perception of learning disabilities shifted within the medical community. Recognition of learning disability as a medical problem by two prestigious medical bodies opened the doors for new ways of looking at learning disabilities. The third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III) of the American Psychiatric Association (1980) listed learning disabilities under the category of "Specific Developmental Disorders," and the World Health Organization (WHO) International Classification of Diseases (ICD) rated learning disabilities as a mental disorder calling it a "Developmental Delay Disorder".

In May, 1980, the Federal Rehabilitation Services Administration convened a Task Force to explore the issues associated with learning disabled individuals under the State-Federal vocational rehabilitation system. Its objective was to develop an action plan that would expand and improve the linkages between the adult LD population and the State-Federal VR program. Additionally, the LD Task Force attempted to identify the initiatives which RSA could undertake both within its own programs and with other rehabilitation agencies and programs, to enhance the quality and quantity of VR services to the adult LD population. The efforts of this Task Force led to a landmark decision by RSA in January, 1981, to recognize "Specific Learning Disability" (SLD) as a handicapping condition qualifying for services in the State-Federal VR system. (Federal Register, Vol. 46, No. 12, January 19, 1981, 5516)

Eligibility

Neither the APA or WHO have developed definitions of "Specific Learning Disability" that are readily applicable to the state vocational rehabilitation service programs in operational terms. Both organizations did identify specific learning disorders as mental disabilities, however, and this recognition is applied to the state vocational rehabilitation delivery programs. The DSMIII Specific Developmental Disorder diagnoses are the most commonly used diagnostic terms in certifying the existence of a qualifying disability in the Pennsylvania Office of Vocational Rehabilitation and other states.

The eligibility for vocational rehabilitation services of an individual with a specific learning disability is determined in the same manner as for any other handicapped individual with a mental disability. This means that a preliminary diagnostic study to determine the person's eligibility must include an examination by a physician skilled in the diagnosis and treatment of mental or emotional disorders, or by a licensed or certified psychologist, or both, as is required by the Rehabilitation Act of 1973, as amended.

With access to vocational rehabilitation services, severely learning disabled individuals may now take full advantage of the delivery of services needed for successful adjustment across the developmental continuum. Ultimately, eligibility will mean that severely learning disabled persons will be able to receive employment assistance in the least restrictive vocational environment, a goal which has never fully been realized by this population prior to this time. (Gerber, 1981)

(For the remaining purposes of this paper, the definition of Specific Learning Disability will be that cited by Dr. Minskoff on page 1 of this issue of *Spectrum*.)

ROLE OF THE REHABILITATION COUNSELOR

General

Regardless of the specific rehabilitation plan eventually developed, the adult learning disabled client will benefit from studied application of the rehabilitation counselor's stock-in-trade: counseling and guidance. Although the counselor's own services will focus primarily on vocational programming, he/she is usually in the position of acting as a services broker or coordinator for the client. The counselor must become thoroughly familiar with the client's "wants" and "needs". Additionally, the counselor should be familiar with local agencies and programs specifically geared

to the learning disabled client. These include learning remediation programs and adult basic education or literacy programs. The counselor should also be familiar with the full range of mental health, substance abuse, and other social support services available. The local chapter of the Association for Children and Adults with Learning Disabilities, literacy council, and school systems can provide assistance in directing the counselor to appropriate programs. At the present time, few programs are designed specifically for the learning disabled adult, and the counselor may find him/herself in the position of having to educate other service providers concerning the nature of learning disabilities. Existing vocational or other programs may be designed primarily for a different type of client and may have to be adapted slightly or substantially to meet the needs of the SLD client. Rendering services effectively requires coordination of a variety of professionals and is, therefore, a challenge to the ingenuity and diplomacy of the counselor.

The establishment of vocational maturity is a fundamental intermediate goal in the vocational rehabilitation of the learning disabled adult. Bingham (1968) found a significant deficit in vocational maturity with preadolescent and adolescent boys who were learning disabled, and speculated that unsuccessful school experiences may have led to the negative attitude of the boys toward work and career choices. Similar problems are manifested by many SLD adults. The need to provide success experiences and vocationally relevant skills has generated an interest in vocational education for SLD adolescents and led to more extensive programming than is available to SLD adults. (Greenan, 1982; Mathews, Whang and Fawcett, 1982) Hands-on experience is an especially effective learning technique for the learning disabled, as these programs have shown. Young adults fortunate enough to have benefitted from such programs may have developed adequate work habits and attitudes, but many other clients less fortunate can benefit from prevocational or work readiness training.

Referral and Intake

The referral and intake stage generally represents the first contact the counselor makes with the client. In many respects, this step represents the most significant interaction of any between the counselor and the learning disabled adult, as the development of rapport and confidence during this initial interview should set a positive tone for all further professional contacts. With no other vocational rehabilitation client population is it more vital that:

- the client be provided all information necessary for understanding the roles and functions of the rehabilitation agency and its service providers;
- and that the client be properly informed of the reason for all requested participation in necessary services, as well as what to expect.

To accomplish these tasks, the initial interview should obtain the following information:

1. **Client History**—personal and demographic data; family background and dynamics; medical information, to the extent known; interpersonal history; psychological functioning; educational background, vocational history.
2. **Behavioral Observations**
3. **School Records**

Diagnostic Evaluations

There currently exists some disagreement as to what constitutes the recommended critical procedures to diagnose Specific Learning Disabilities. Part of the disagreement stems from the relative newness of the disability as it applies to the adult population; much of it from the very nature of the disorder. SLD is a heterogeneous disorder, with unknown etiology. As indicated previously, it is most likely not one but a number of interrelated disorders caused by different etiological agents. A single diagnostic tool attempting to identify a particular dysfunction, either cortical or functional, will, at best, only identify a portion of the SLD population.

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HILL TOP PREPARATORY SCHOOL



HILL TOP SPECTRUM

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Rehabilitation Counselors

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This is not meant to imply that professionals are not able to diagnose SLD. The critical point to emphasize is that diagnostic tools only serve as aids in the diagnostic process. It is the *interpretation* of information made by qualified professionals that constitutes the "diagnosis."

Furthermore, it is the responsibility of the VR counselor to ask the diagnostician appropriate questions. That is, in addition to the identification of a specific disability, the professional can and should be called upon to comment on how the individual's particular handicap may impact on his/her vocational pursuits. This type of information will assist the counselor both in helping to assess a substantial handicap to employment and in identifying the appropriate array of VR services.

Three major types of diagnostic evaluations are seen as a minimum in the assessment of SLD clients:

1. Medical Assessment
2. Psychological/Educational Assessment
3. Vocational Assessment

Other specialty examinations should be scheduled as indicated from findings of either the medical or psychological/educational assessments.

Medical Assessment

The medical assessment is viewed as an essential component of the diagnostic process as it serves to both:

- identify any physical condition that may be contributing to or causing the learning problem.
- identify any physical problem that may exist concurrently with the learning disability.

These two functions are important as knowledge of the client's medical condition may have dramatic implications for rehabilitation program planning. The medical assessment should include a thorough medical history and a comprehensive medical examination. Specific attention should be paid to any positive response on the medical history questionnaire. Similarly, any abnormality found during the medical examination should be carefully evaluated relative to a possible involvement with the client's learning disability, particularly positive neurological findings and/or vision or hearing difficulties. Some of the questions which might be posed for the examining physician are:

- is there any evidence of a physical or neurological disability?

- are there any physical limitations which would interfere with the client's ability to obtain gainful employment?
- if a physical limitation prevents employment, will medical or surgical treatment increase the client's chances for gainful employment?
- based upon medical findings, should any restrictions be placed upon the client's physical activities?
- are there any additional laboratory procedures and/or specialty examinations recommended?

(*Specific Learning Disabilities - A Resource Manual for Vocational Rehabilitation*, 1983)

Psychological Assessment

A learning disability is not diagnosed on the basis of objective laboratory tests, such as is involved in many physical disabilities, or on the basis of an objective psychometric test, as in the diagnosis of mental retardation. Rather, learning disability is a diagnosis based on psychometric discrepancy, with the magnitude of the discrepancy needed to establish a diagnosis established by administrative policy rather than by scientific criteria. (Hartlage and Telzrow, 1983) Specifically, a diagnosis of learning disability usually is based on a discrepancy between measured ability (e.g., IQ) and measured academic achievement (e.g., reading and calculating skills). The diagnosis is based on exclusions rather than confirmations. If a person's reading and/or math levels are sufficiently lower than IQ testing indicates they should be and if such potential explanations as severe emotional problems, visual/hearing/motor handicaps, and mental retardation are ruled out, then the existence of a learning disability is inferred.

Because the presumptive etiology of specific learning disability is of neurologic origin, and the requirements for eligibility usually depend on psychological assessment, neuropsychological evaluation should be considered as a diagnostic procedure of choice.

Neuropsychological Evaluation

Brain injury and cerebral dysfunction, although not necessarily involving cerebral tissue damage, are considered by many as primary and basic causes of learning disabilities. (Hallahan and Cruickshank, 1973; Mykelbust, 1964; Strauss and Lehtinen, 1947) The emphasis in contemporary definitions of specific learning disabilities focuses on processing difficulties which involve understanding, perceiving, or expressing language or concepts which manifest themselves in problems relative to listening, thinking, speaking, reading, writing, spelling, and doing mathematical calculations. The importance of neuropsychology in dealing with perceptual deficit and related processing problems has been established, and the neuropsychological evaluation is already playing a major role in the diagnosis and determination of eligibility for rehabilitation services. More importantly, its utilization in the actual process of vocational rehabilitation has begun, though on a limited basis thus far.

The two most widely used neuropsychological test batteries are the Luria-Nebraska and the Halstead-Reitan.

Vocational Assessment

The third major type of assessment that is recommended as part of a comprehensive diagnostic evaluation is a vocational assessment. A vocational assessment may take many forms and encompass a number of levels. First, the vocational rehabilitation counselor should find out what the client's own vocational goals are. If the client is unsure of goals, and many are, knowledge about hobbies and leisure pursuits may provide a basis for further exploration of types of activities the client enjoys and does well. Do not assume that the expressed goal is unrealistic simply because it appears to require better academic skills than the client possesses. With appropriate learning remediation and/or job modification, the client may be able to attain his/her goal. A recent ACLD survey of SLD adults revealed a surprising number of people functioning in professional level positions. (Chester, 1982a, 1982b)

Secondly, the counselor should make a preliminary determination of the client's vocational aptitudes and strengths, based on previous job history, details of psychological and educational testing, and behavioral observations of the client. Areas can be pinpointed in past jobs that were problematic,

possibly due to the client's learning disability. Find out what special adaptations and coping skills the client has developed in previous jobs and in daily living situations. This information will provide an idea of what types of jobs the client may be best suited for, how flexible and adaptable the client is, and what types of job modifications may be necessary for a particular client. When obtaining a psychological or neuropsychological evaluation, be sure to specify that the examining psychologist describe the client's limitations and strengths in functional terms, and request recommendations concerning suitable jobs and types of treatment and training recommended.

The third level of vocational assessment should include more formal vocational aptitude and vocational interest testing. Numerous standardized vocational aptitude and vocational interest inventories are available to aid in this assessment process. Care should be exercised, however, in the selection and administration of such tests, as they may provide misleading results with the clientele. Do not, for example, select a test that is likely to call upon the client's weakest learning modality.

A fourth level of vocational assessment should include a diagnostic vocational evaluation. Such assessments measure areas of strengths and interests in greater detail than previously mentioned procedures. Commercial vocational evaluation systems such as Micro-TOWER, JEVs, VALPAR, Singer, TAP, and WREST, offer the client "hands-on" experiences in a variety of job simulations, and provide the vocational rehabilitation counselor with job performance results in a standardized setting. While such work sampling procedures can be extremely helpful in assessing a client's vocational potential, the evaluation process may need to be adapted to the SLD client by providing a multi-sensory approach to instructions (oral, written, and pictorial), and allowing extra time for the client to complete tasks. It may be necessary to give the client directions in small increments or to ask the client to repeat the instructions back to be sure they are understood. The work evaluation staff should be briefed on the psychological test results and the client's learning style, and be given some specific suggestions on how to assess the client. In deciding what trades or skills to include in the evaluation, the counselor should try to adhere to the client's expressed goals as closely as possible unless they appear to be completely unrealistic. Many learning disabled persons are succeeding in fields that first appeared to be beyond their reach. Keep an open mind! (Specific Learning Disabilities - A Resource Manual for Vocational Rehabilitation, 1983)



Richard Nocella, Transitional Program Director, and Kristin Jones, a student, discuss post-secondary options.

Prevocational Programs

Many learning disabled adults require prevocational programs to provide basic skills needed to successfully complete vocational training programs or to compete successfully in the job market. The need for functional literacy has increased as our society has become more technological and complex. Functional literacy or functional competence refers to a person's ability to successfully perform tasks necessary within the community or vocational environment. There is an almost universal need for a certain minimal ability to understand and use language, read with understanding, write, and compute. There are fewer and fewer entry-level jobs which do not require basic competency in reading and math. Security and stability of these low-level positions is often questionable with advances in automation and technology. Furthermore, the SLD individual is often prevented from advancement beyond entry-level positions only by his/her low academic skills. Training programs, even for manual and service jobs, require mastery of texts and other written material. It is a rare program that does not require at least a sixth grade reading level for successful completion, and many recommend higher levels.

In addition to raising academic levels, prevocational programs usually also develop good, responsible work habits, including punctuality, appropriate personal appearance and dress, handling interactions with superiors and co-workers, timely performance of duties, and dealing with job complaints and dissatisfaction. Prevocational programs often encompass the skills involved in getting a job, including reading want ads, filling out job applications, techniques for interviewing, and writing resumes or business letters. Such a program can also provide an opportunity to address the broader needs of the worker to function productively within his/her family and the community. It can provide the worker with background in understanding wages and deductions, budgeting, using banking and credit systems, and locating community resources.

Severity Determination

As interest and information about the newly certified vocationally handicapping condition "SLD" spread, and more and more known, suspect, and "maybe" LD adults present for services, the question of severity of the handicap increases in importance, and will likely have implications for more widespread concern. A key

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phrase in the determination of severe handicap in the State-Federal VR system is "functional limitations." This, of course, applies to learning disabilities the same as it does to any other disability. The Federal Guidelines for determining severity promulgated subsequent to enactment of the Rehabilitation Act of 1973, and widely used, did not specifically address learning disabilities since it was not a recognized disabling condition at the time.

The project staff, implementing a RSA grant awarded to the Vocational Rehabilitation Center of Allegheny County in Pennsylvania to develop a Comprehensive Vocational Services Model for Persons With Specific Learning Disabilities, has developed proposed severity determination guidelines for Specific Learning Disorders. The intent was not to circumvent the State Board mandated Functional Limitation Factors, but rather to provide a rationale by which a counselor could objectively quantify relative severity of diagnosed learning disabilities. So long as they continue to be mandated, the appropriate functional limitations statement, or statements, would continue to apply.

Criterion levels were established in three categories considered to be most relevant to the severity of a learning disability, and which were readily quantifiable. The diagnosed SLD client would be considered to be severely handicapped in terms of employability if a minimum of three criteria items from the total of seven in the following categories were met.

Part A — Functional Literacy

1. **Reading Words** (decoding)
2. **Reading Comprehension**
3. **Arithmetic** (computation)
4. **Spelling.** Spelling skills at or below a 4.9 grade level.

Part B — Communication Skills

5. **Conceptualization Ability** (Receptive & Expressive Language). Research indicates that Vocabulary, Similarities and Comprehension subtests of the WAIS-R reflect a person's ability to understand and form concepts. The SLD person who averages 7 or below across these three measures has a serious communication disorder.
6. **Comprehension of Written Language** (Receptive Language). The SLD person with a reading comprehension score two or more years below his/her decoding score has a serious communication problem providing the reading comprehension score is

below the Eighth Grade level. (Note: This level has been selected based upon literacy level by the National Institute of Education, U.S. Department of Education).

Part C — Deficits in Attention and Memory. Research indicates that Arithmetic, Digit Symbol, Information and Digit Span Subtests of the WAIS-R reflect auditory and visual memory function, distractibility, and attention span.

7. The SLD client with a severe deficit in attention span will average 7 or below across these four measures.

The recommended procedure provides for the exercise of counselor judgement in making the severity determination. In cases where the indicated criteria are not strictly met, the counselor is encouraged to consider:

- a. the extent of the discrepancy between the client's overall potential (as suggested by psychological testing and other information) and his academic achievement.
- b. the total number of applicable criteria and the number of criteria which are very nearly met.
- c. pertinent information from client history (emotional, social, familial, educational, vocational and medical).
- d. behavioral observations of client such as general appearance, language use, and apparent level of motivation and cooperation.
- e. relevant information from any other source such as school records, former or current employers.

CONCLUSION

Vocational rehabilitation of the SLD adult does not end with prevocational training. Hopefully, technical training or college will be realistic options available for continuation of the rehabilitation plan. And, of course, job placement will be the ultimate goal in the majority of cases. The challenges and requirements of programs in post-secondary education, technical training, and job placement considerations are suitable subjects for further reporting. □

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VR Services

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& Baker, in press). The high schoolers did not report significant problems in vocational or personal adjustment. One hundred forty-three teachers of the learning disabled were asked their perceptions of learning disabled students. Their perceptions of academic, vocational and personal adjustment problems more closely resembled the views of the adults than those of the high schoolers. Possible explanations for this difference between the adults and high schoolers may be due to over-protection by special educators and parents resulting in learned helplessness and lack of accurate self perception. When persons with learning disabilities leave high school, they have inadequate vocational skills and an unrealistic view of themselves and then they are jolted into realization of their situations. This points out the critical need for providing career and vocational education to learning disabled high schoolers to prevent the problems during the transition from school to work. It is also important that training in independence, self advocacy, and self awareness be provided to the learning disabled high school student to prevent possible problems with adult adjustment.

Data relative to barriers to vocational rehabilitation and employment of the learning disabled were collected by surveying 948 professional providers of services to learning disabled persons, 212 advocates for the learning disabled, and 326 employers. Some advocates did not know of the availability of vocational services for the learning disabled, thereby presenting a barrier to services. A number of service providers, especially vocational rehabilitation counselors, expressed the desire to know more about learning disabilities so that they could more effectively provide services to such clients. The employers were asked if they would hire the handicapped for jobs they supervised, and 72% responded yes; but when asked if they would hire the learning disabled, only 51% responded positively. This prejudice against the learning disabled by employers must be conquered through a program of public education (Minskoff, Sautter, Hoffmann, & Hawks, 1987).

Identification of factors related to job placement and job maintenance for the learning disabled indicated that having held previous jobs was a negative factor. In other words, persons who had previous jobs were less likely to be successfully placed in jobs. This may be due to their expectations of highly paid jobs after voca-

tional rehabilitation or their negative experiences and learnings on prior jobs. This finding points to the need for providing training at the secondary level before learning disabled persons have negative experiences and learnings on their first jobs.

A model diagnostic battery was developed and field tested with learning disabled adults. This battery includes test and clinical information regarding deficits in academics, cognitive processing, psychological adjustment, speech/language, medical/balance, and vocational areas. Because of the many manifestations of learning disabilities in adults, such a comprehensive battery must be used to identify all possible weaknesses and strengths. Such a battery requires a multi-disciplinary team including at least a psychologist, physician, speech/language clinician, and vocational evaluator. With a comprehensive battery of this nature it is possible to generate recommendations for vocational training, higher education, academic remediation, mental health services, social skills training, compensatory strategies training, and placement in a job appropriate for a person's strengths and weaknesses.

Treatment programs in the following areas were developed and evaluated by the Research and Demonstration Project: vocational consultation, job seeking skills, functional academics, coping strategies, social skills, and self awareness. Not all treatments are needed by all adults with learning disabilities. Only those areas in which a person has a deficit as indicated by the assessment results should be given treatment.

Learning disabled adults in vocational rehabilitation, by definition, have vocational problems. If a learning disabled person is in a training program, then the person's vocational instructor must be provided with consultation so that the person's problems can be circumvented and the vocational training program successfully completed. For example, if a learning disabled person continually asks questions after directions have been given, it might be suggested that the instructor have the learning disabled person paraphrase each direction after it is given, use written directions, demonstrate, and/or have another trainee, who is willing, serve as the learning disabled person's buddy for the purpose of clarifying directions.

If a learning disabled person is placed in competitive employment, it is critical that the job match the strengths, weaknesses, skill levels, and interests of the person. Once on a job, occupational consultation may be needed. With this approach, a vocational counselor is available to help an employer and learning disabled worker solve problems which arise in the workplace. Such problems may occur when there is a change in office technology or stress resulting from having to work overtime to meet production deadlines.

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VR Services

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Some learning disabled persons require help with job seeking skills. They need to learn where to find jobs, effective interviewing skills, how to complete job applications, and telephone skills.

Most of the learning disabled persons in vocational rehabilitation continue to evidence significant academic problems. For such persons, a functional academic program is needed. If they are in a vocational training program, they will need help in meeting the academic demands (e.g., reading a training manual, writing order forms, measuring, handling money). In addition, they need help with everyday academic skills, such as reading want ads and labels, telling time, and budgeting.

Some learning disabled adults have cognitive processing problems in attention and memory which make it difficult for them to perform adequately in a work setting. For such individuals a coping strategies program is needed to develop compensatory skills to overcome these processing problems.

Learning disabled adults with social skill deficits have difficulties getting along on the job and may have no friends. For such persons, there is need for a social skills group which stresses verbal and nonverbal communication skills involved in conversation, giving feedback, problem solving, and assertiveness. Such skills should improve both vocational and social adjustment.

Some learning disabled persons have not come to grips with who they are. They need a self awareness training program to help them develop an understanding of both their weaknesses and strengths. They must learn to accept themselves for what they are and what they can become.

Extensive diagnostic and treatment services are needed for learning disabled adults to become vocationally, socially, and personally competent. Such services cannot be provided by vocational rehabilitation agencies alone. Rather, mental health, educational, and advocacy organizations must also be involved in a total push toward providing maximal services for learning disabled adults.

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Learning Disabled Adolescent Viewed at Risk for Drug and Alcohol Abuse

Benson E. Gever, Ph.D.

The learning disabled adolescent is vulnerable and at risk. The vulnerability has deep roots in the various developmental delays or deviances which were really there from the beginning and posed numerous handicaps at the crucial stages, turning points, and transitions for this child. There are primary weaknesses in perception, memory, cognition, language functions, and in the nonverbal functions which disrupt the child's focus, orientation toward learning and appropriate skill development at school and in all of the other important classrooms of his or her life. There is no singular syndrome which characterizes learning disability. Rather, there is wide variability in the nature and extent of the disability depending on the assumed etiological factors; genetics, biochemistry, allergy, neurological dysfunction, nutrition. In some ways the child has some flaws in the basic psychological equipment he/she needs to cope successfully with the normal demands and expectations of his/her life. As a result the child experiences a more than usual dose of stress and frustration, or in other words, he/she becomes overdosed with failure.

Failure has a highly toxic influence on the shaping of personality and can only exaggerate the underlying vulnerability. However, the eruption of burdensome social and emotional difficulties in learning disabled children and adolescents is usually the effect of a complex interaction of stresses and strains on the already weakened "ego". While there is a common core of vulnerability associated with their years of stress and failure, the typical description of the "emotional overlay" to the disability is an oversimplification. Multiple sources of the emotional and behavioral disturbances seem likely. In many, there are structural deficiencies of the "ego" from the beginning which result in deviant activity levels, temperament and impulse control. Clearly, this restless, impatient child is uncomfortable with himself/herself. According to Chess and Thompson (1977) this condition may be the result of a pathological exaggeration of temperamental characteristics. Note, for example, the characterization of the difficult child—highly active, easily irritated and angered, distractible, overly persistent, prone to power struggles. Secondly, to the extent that the child is impulsive, irritable, and affectively labile, he/she becomes limited in the capacity to evoke positive responses from the significant others in his/her environment. To put it somewhat rudely, if such a scale existed, this child might receive rather low ratings on a "loveability" scale. Finally, the struggles in acquiring skills and growing sensitivity to failures in relationship to siblings, peers and classmates erode the sense of competence and mastery which generalizes throughout the personality. He/she is caught in the context of failure which becomes incorporated as a major part of self-definition.

While many individuals seem to compensate reasonably well with later developmental achievements (i.e. success in sports, art, social activity, the work world) others become even more vulnerable, pained, and reactive as they move toward and through adolescence. In fact, the primary weaknesses at this point may become obscured by more attention seeking symptoms as the adolescent searches for a "career" which will preserve his/her identity.

It is very difficult to predict the developmental course of the learning disabled child and the shape of things to come at adolescence. While it is true that for some the primary weaknesses get better over time through maturation or compensation, this is not the case for others. Many behaviorally restless and hyperactive children remain hyperactive, demanding and difficult through their teenage years and into adulthood. In some cases, the disability changes form or continues to exert an influence through

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Adolescents At Risk

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the more subtle residual effects. Longitudinal and follow-up studies have documented the stability of a variety of symptoms through the teenage years including restlessness, impulsivity, hyperexcitability, aggressiveness, moodiness, distractibility, low self-esteem, and poor school performance. And of course, it has also been noted how these traits seem to reflect a potentially dangerous affective core which is gradually forged into varied forms of psychopathology including mood disorders, delinquency, depression and chemical dependence.

Several years ago I participated in a study of adolescents in an inpatient psychiatric center for incidence of learning disability (Horowitz, 1981). The major finding was the presence of learning disability in 38 percent of the sample population, a finding which was consistent with several other reported incidence figures. Three different subgroups within this population were defined. The group labeled *Diffuse Developmental Disorder* was characterized by lifelong deficits in attention, cognition, motor functioning and social adaptation. These youngsters were seen as odd, infantile, asocial and behaviorally inappropriate. While distortions in reality testing were characteristic, only two were diagnosed as psychotic. The second group labeled *Discrete Attention-Cognitive Group* presented more mild and specific deficits in attention, cognition or educational skills. These patients were not as readily identified at school as being special needs kids and were often seen as resistant or under-achievers. They tended to suffer from achievement anxiety, intense fear of failure and depression which appeared to be associated with a loss of confidence in their sense of mastery. Finally, the *Affective-Motor Dyscontrol Group* demonstrated significant disturbances in behavior and emotional control and regulation. Hyperkinesis, interpersonal difficulty often related to over-aggressiveness were characteristic. These adolescents were intrusive, impulsive, easily frustrated, and hypersensitive and reactive to all forms of stress. Socially, they seemed naive and disorganized by interpersonal events, by normal rules, standards and expectations. While the symptom pattern varies, it is of great significance that there

is a common element of frustration, vulnerability, and shame, in large part the product of excessive failure which is at the affect core of all individuals who have experienced learning disability.

It is out of this vulnerability and pain that the learning disabled adolescent searches for a career that will somehow preserve his/her faltering identity. The choices made by parents and teachers simply didn't work. Unfortunately, the judgement of the learning disabled adolescent at this point is tainted by a history of failure, rejection, often social isolation and an erosion of self-esteem. No wonder that these adolescents turn to depression and the high drama of suicide, delinquency, or alcohol and drug abuse, not only as a form of tension release and relief, but as a career, a pervasive, embracing activity and form of identity which gives them meaning and self-definition. The "head" or "druggo" now has a purpose and a peer group to support his/her new found ideology.

There is research to support the idea and the concern that there is a relationship between learning disability and the development of alcohol and drug abuse in later years. Several studies, for example, have reviewed the developmental histories of adult alcoholics and have found a disproportionate incidence of hyperkinesis, attention deficit disorders and learning disability in their childhood and adolescence. Attention deficit disorder, the current diagnostic label being used for that behavioral syndrome so often associated with learning disability, appears to be strongly linked to drug and alcohol use. Even when compared to children and adolescents with "other problems," the attention deficit disorder population appears to be more likely to become problematic users. There are some complicating factors in this research, however. For one, the long term effects of alcohol and certain drugs parallel the primary symptom picture of many learning disabled adolescents. Memory loss, intellectual disorganization, restlessness, impatience and impulsivity may represent the result rather than the cause of the problems. Secondly, children of alcoholics who are also a high risk group tend to show similar problems as a result of the tensions and strains in the family, dysfunctional role modeling, and as a form of expression of their depression.

In sum, many learning disabled students may be characterized as "difficult children" in that they are tense, restless, provocative, overly aggressive and unresponsive to many of the reinforcement and management techniques successful with other children. In sum, the pattern remains stable through the teenage years and creates an internal discomfort which makes this youngster more likely to experiment with drugs. In fact, my experience in working on an inpatient preteen unit has indicated that a surprising number of children are becoming seriously involved with substance abuse. Additionally, in taking drug and alcohol histories from adolescents and adults it is commonly reported that there was regular usage during the preteen years. There is a recent hypothesis that these children and adolescents may be attempting to medicate themselves for their chronic discomfort. In fact, it has been suggested that addicts are selective in their choice of drugs as a function of their varying symptom pictures.

Once the learning disabled adolescent chooses a substance abuse "career" out of vulnerability and pain, a stable pattern of attitudes, habits, and social behaviors follow. The addiction begins to take on a life of its own which obscures the underlying causative factors. In fact, for many it becomes a central life theme. Choices about what to do and who to do it with are no longer necessary. The adolescent is now an "alcoholic" or "drug addict"; however, through manipulation, avoidance, massive denial, and collusion with naive family and friends, this fact is distorted by self-destructive delusion and ignorance. There will be no change until some form of realistic confrontation and problem identification begins.

Jim H. is a twenty-seven year old alcoholic. He has had a life-long learning disability due to anoxia associated with birth complications. His speech is somewhat garbled and the flow of his language is halting and dysfluent; however, his thoughts are clear and his self-descriptions are sensitive,

insightful and poignant. Jim had been placed in special educational classrooms and some state funded private schools since the primary grades. He graduated from one of these schools but he hides this fact because the school was also known for its programs for the mentally retarded. Jim started his career as an alcoholic at age 11, and his drinking pattern and drug usage rapidly accelerated through his teenage years. The statement, "All we would do was go to the garage and get wasted" seems to characterize much of his adolescence. Jim is married and has four children. He is out of work and unable to care for his family. He is seriously depressed, has flirted with suicide and he is currently a patient on a substance abuse unit in a psychiatric hospital. In his very first interview, he talked with shame and humiliation about his learning disability and his need for special schooling. He talked about being called a reject, a sped, a retard by his peers. Jim stated that he felt as if he were never really a part of his family either, that he wasn't smart enough. He felt his parents didn't have time for him, that he couldn't really communicate with family or friends because he didn't feel equal to them.

In Jim's case, the sequence of events was reasonably clear, but in many cases, once the individual is committed to his or her career, the important influences are less obvious. Many addicts are being counseled for or treated for their addiction without any awareness of the role played by their learning disability. The significance of this association has been recognized only recently and there are still many treatment programs which ignore the educational issues.

There are a variety of programs and approaches to treatment, some of which develop out of dramatically different philosophies. One position suggests that the addictive behavior must be confronted, attacked, and broken down; that a recovery process must be underway before the individual can honestly look at some of the underlying dynamic issues. At the other extreme would be the view that underlying emotional dynamics must be resolved before a real and stable change is possible. Of course, what makes most sense is an integrated multimodel approach. Direct confrontation, group support, education about drugs and alcohol and an all encompassing philosophy and structured approach to life such as that offered by A.A. and N.A. may all be necessary to change the adolescent's career commitment.

While there has been an enormous increase in treatment programs, there has not been a commensurate advance in the development of prevention programs. Many of the school-based drug and alcohol educational programs appear to be too cognitively oriented and don't really focus on or touch the kids "at risk" for future abuse. The Horsham Foundation in Pennsylvania has recently received a grant to begin a chemical dependency prevention program for children. The target population will be children between the ages of 6 and 12 who have been diagnosed as hyperactive or attention deficit disorder and who are children of substance abusers; indeed, a "high risk" population. They will participate in an 8 week after-school program which will offer group counseling dealing with issues of self-esteem, family interaction patterns and values clarification regarding the use of drugs and alcohol. There will also be a "hands on" activities component designed to build and enhance practical skills (educational, sports, crafts, etc.). Some kids glow with pride through the completion of their own creative Lego constructions. The notion of building strength and positive identity through competence and mastery is an essential but often omitted programmatic thrust and a theme I would like to develop in a more general sense.

You can't stay sober long if you return to a life fraught with insurmountable obstacles and incessant failure. Too many learning disabled adolescents have overdosed on failure and disappointment. They have existed in a context where the balance of success to failure has been tilted in a negative direction. All efforts at prevention and treatment must take this fundamental fact into consideration. There must be a serious effort to alter this context, to shift the adolescents' experience of the success to failure ratio. Good educators plan curriculum and educational strategies on this basis. They attempt to teach at appropriate educational levels, that is at the level where there is enough complexity for challenge but where the student is able to win most of the time.

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HILL TOP PREPARATORY SCHOOL



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M.D. Discusses Assessment, Treatment of Depression, Suicidal Tendencies in Children with Learning Disabilities

G. Pirooz Sholevar, M.D.

Multiple Views on Depression in Children

There are multiple views on the existence of depression in children although the controversy seems to be decreasing in recent times. Some of the existing views are based on the historical notion that children are happy by nature and unhappiness is a phenomenon of adult life due to the heavy responsibilities of an adult person. This point of view is obviously indicative of the historical lack of sensitivity to the feelings and conflicts of young children. However, this historical notion affects the contemporary views of childhood depression to some degree.

There are 4 major views on childhood depression at the present time.

A. Children do not suffer from a depressive disorder or syndrome.

The proponents of this point of view do not deny the existence of sad mood or affect in children but they believe this is a temporary phenomenon and does not reach the intensity or duration necessary for the diagnosis of a depressive disorder or syndrome. The proponents of this point of view have generally argued from a theoretical point of view. Rie was the first proponent of this point of view, claiming that children do not become depressed due to relatively immature superego and conscience development and, therefore, do not have the internal critical agency necessary for self-reproach, guilt feeling and the development of depression. More recently, Lefkowitz has argued that the natural history of depression in the children indicates a temporary phenomenon and does not follow the pattern of adult depression with its distinctive and recurring depressive episodes. The influence of the first point of view has been decreasing in recent times.

B. Childhood depression is different from adult depression and has its own broad-based symptomatology. Such recurring symptomatology can include a range of disorders including school phobia, enuresis, and delinquency.

C. The depression in children is frequently masked by other symptomatology such as the school phobia, run away behavior, etc. The difficulty with this point of view is that it would propose that the bulk of childhood psychopathology consists of depression and leaves little room for other types of psychopathological disorders in children. The concept of masked depression was initially proposed by Glaser and subsequently developed by Cytryn and McKnew.

D. Depression in children is a distinct disorder similar to its adult counterpart and can be diagnosed by similar restrictive criteria such as the ones proposed by DSMIII. Puig-Antich, Poznanski and Carlson are representative of this school of thought.

Theoretical Models of Depression

A. Psychoanalytic Model: The psychoanalytic model emphasizes the lowering of self esteem as the central major organizing phenomenon in depression. The lowering of self esteem is based on self criticism due to hostility turned against the person following the loss of an ambivalently loved object.

B. Behavioral Reinforcement Model: This emphasizes the lack of adequate positive reinforcement in the interaction of the depressed child with his/her environment. The lack of sufficient positive reinforcement may be due to lack of such reinforcers in the environment or due to a failure to develop the necessary skills to elicit positive reinforcement from the environment.

C. Learned Helplessness: This model emphasizes the inability of the person to conceptualize the relationship between feelings of effectiveness and positive feelings about self to the utilization of the reinforcements in the environment. Therefore the child ends up "giving up", feeling that he/she has no way to win.

D. Cognitive Model: This model emphasizes three major conceptual difficulties in depressed people. They tend to have a negative view of themselves, a negative view of the world around them (including objects) and a dim view of the future.

E. Life of Stress Model: This model emphasizes the presence of multiple stressful and unpleasant environmental factors resulting in the child feeling overwhelmed.

Epidemiology of Childhood Depression

Epidemiology of childhood depression has been inadequately studied. There is a consensus that the level of depression in children is consistently underestimated in the clinical population as well as in random natural population. The best study is probably the study of Isle Wight by Michael Rutter. Rutter estimates the presence of depression in ten year olds to be .15% and for 15 year olds at the rate of 1.5%. These figures are decidedly below the estimates of the prevalence rate of depression in adults.

Clinical Features

The major clinical feature of depressive disorder is "dysphoric mood" which shows itself by feelings of depression, sadness, dispondency and irritability. The loss of interest or lack of pleasure in activities is closely associated with this feeling.

There are several associated symptoms, many of which can be present concomitantly with the dysphoric mood. The major associated features include disturbances of appetite, (lack of appetite or overeating), sleep disorders (insomnia or hypersomnia), loss of energy, agitation or retardation, loss of interest in activities, feeling of self reproach or guilt (worthlessness or self depreciation), diminished ability to concentrate and recurrent thoughts of death and suicide. Generally, five of the above eight symptoms have to be present to make the diagnosis of childhood depression.

The duration of the dysphoric mood is different according to different classification systems (DSMIII, Weinberg, RDC). Generally, the dysphoric mood should be present for a duration of one to four weeks before making the diagnosis of depressive disorders.

Methods of Assessment

In addition to the clinical interviews, a variety of assessment instruments and inventories are utilized for making the diagnosis of childhood depression. The most common ones are Children's Depression Inventory (CDI), developed by Maria Kovack, and Kiddie-SADS, developed by Puig-Antich. CDI is a 27 item questionnaire which is self-administered by the children and measures a variety of areas including the depressive moods.

The biological markers of depression have not been established as reliable diagnostic tools yet. They include Dexametasone Suppression Test (DST), which has been most widely studied in depressed adults and children and has exhibited contradictory results due to the high incidence of false positive and false negative findings. Other biological markers include the disturbances in growth hormone and shortened REM latency in depressed children.

Depression in Learning Disabled Children

The relationship between learning disability and depression is a significant one because depression reduces the cognitive capacity of children (Weingartner et al 1981). A major study of the presence of depression in children with learning disabilities was undertaken at Irving Schwartz Institute in Philadelphia by David Goldstein et. al. They studied the children's IQ, math and reading ability by administering Keymath and Woodcock Reading Test. Children's Depression Inventory (CDI) was administered to the children by reading the questions to them. Eighty-five children were tested and divided into four groups. The largest group consisting of 44 children had an IQ over 85 and exhibited no significant emotional or organic factors. The other two major groups included children with IQ's between 70-85 without significant emotional-social problems and a third group of children with IQ's of 85 and above with emotional difficulties.

Overall, the mean score for the children on CDI was 13.78 which was significantly above the normative score of 9.27 for average children. More importantly, 30% of the first group, 27% of the second group, and 24% of the third group exhibited a mean score above 19 which is indicative of severe depression.

The above study demonstrates that a significant number of learning disabled children in this sample were concomitantly suffering from a serious level of depression as exhibited by CDI.

Treatment of Depression

The major treatment modalities for children include individual therapy, family therapy, and medication.

The study of Klerman has concluded that the most effective method of treatment of adult depressed patients is a combination of individual and interpersonal psychotherapy, together with pharmacotherapy (anti-depressants).

In individual therapy, the focus is on the development of a relationship with the child with the goal of helping him/her try to arrive at a better self-object definition in order to enhance self-esteem. The child is assisted to resolve difficult life circumstances and learn ways of eliciting positive reinforcement from the environment. The latter approach has been particularly emphasized by behaviorists.

In family therapy of depressed children, the focus is on enhancing the ability of the family to define their problems and solve them through collective efforts of the family members. Some of the specific major issues include the concomitant depression in parents, the overall paucity of reinforcement in the family environment, limited problem-solving ability, and concentration on deficiencies rather than assets. The family system tends to be rigid, inflexible, with poor patterns for handling aggression and a tendency toward scapegoating. The overall goal of family therapy is to improve the family relationships in ways that would result in more productive means of relating and problem-solving and diminishing the non-productive family patterns.

Other goals of family therapy are the establishment of effective generational boundaries, improvement of parental marriages, introduction of more flexibility in the family system, encouragement of conflict resolution and reduction of scapegoating.

The use of anti-depressants, particularly the tricyclic ones, has been quite encouraging with adolescents and pre-pubertal children. The medication should be monitored closely for side effects.

Hospitalization may be necessary in cases of treatment resistant depressions, severely suicidal children or adolescents, or when effective treatment planning cannot be achieved in the out-patient service.

Suicide

Suicide is the third major cause of death in adolescents, falling closely behind accidents and homicides. Considering that many car accidents, particularly single vehicle ones, and homicides are disguised suicidal attempts, suicide may very well be the number one cause for death for this group.

The rate of suicide in adolescents has increased dramatically in the past two decades. In the younger adolescent, ages 15 to 19, the number of successful suicides in 1975 was 1,594, which indicated 124% increase over the previous two decades. This places the rate of suicide at 7.6 per hundred thousand. For the older adolescent, between the ages of 20 to 24, there were 3,142 suicides in the same year indicating a 132% increase in suicide rate over the previous two decades, establishing a suicide rate of 16.5 per hundred thousand for this age group. The number of suicidal attempts were somewhat more difficult to establish, but it is estimated that for every successful suicide, there are a hundred suicidal attempts. This places the yearly number of suicidal attempts at 400,000 people per year for this age group.

The major reason for increase in suicide is considered the weakening of the family system as an institution which can no longer act as a potent force in prevention of suicide.

Methods of Suicide

The use of firearms, hanging, and poisoning by gas and solids are the major methods of suicide utilized by suicidal males. The suicidal women tend to resort

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Depression, Suicide

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to less violent and lethal methods including poisoning by drug overdose. Jumping from high bridges is a particularly popular suicidal method for women in several locations.

Etiology of Suicide

The major disorder associated with suicide is one of childhood depression. Depression poses a significant challenge due to its significant underreporting in children and adolescents. One study indicates that three out of four depressed children are not recognized even by trained mental health professionals. The likelihood of failure to recognize suicide is obviously greater for untrained people.

The use of drugs and alcohol has been implicated as a major factor in adolescent suicide, at least in several studies in different parts of the country. The use of drugs and alcohol may be more of an associated disorder rather than an etiological one with many suicidal adolescents. In other words, the same factors resulting in alienation of the youth from the family, peer group and the schools may lead to drug use, as well as suicidality.

The parents of suicidal adolescents have exhibited a high incidence of certain symptomologies. The fathers of suicidal adolescents have tended to exhibit depression and lower self-esteem in comparison to a control group. The mothers of suicidal adolescents have exhibited suicidal ideation and anxiety. The suicidal youths seem to combine the factors from both parents.

A sensitive analysis of factors resulting in suicide has been proposed by Tischler. He has described suicidal acts as progressing through three different stages including the first stage of long-standing factors, second stage of escalation of the behavioral problems and the third stage of the breakdown of romantic love. In the first stage, the suicidal adolescents have exhibited a preponderance of losses particularly in their early childhood. Twenty percent of the adolescents had one or two parents who had attempted suicide, 40% had a parent or a friend attempting suicide, 72% have lost one or two parents through death, divorce or separation. Fifty-eight percent of the adolescents

had one parent who was married more than once. Eighty-four percent of the adolescents living with step-parents exhibited significant adjustment difficulties with the step-parent. Other factors included marked residential mobility and significant environmental changes.

In the second stage, there is an escalation of the difficulties between the adolescent and the parents resulting in the withdrawal of the adolescent from the family unit and other supportive environments. The views of parents and the children differed markedly. From the point of the adolescents, they were exhibiting everyday adolescent behaviors exhibited by their peers. However, the parents viewed adolescent problems as significantly different from norms and posing great challenge to parental authority. The escalation of the problems generally brought about the withdrawal of the adolescent from the family unit, resulting in marked isolation of the adolescent and lack of support. Concomitantly, there has been a high level of physical symptoms reported by the adolescent and the parents. The above factors in combination with other factors has resulted in gradual withdrawal of the adolescent from the peer group, non-attendance at school, and withdrawal from the major supportive institutions for the adolescents. As a result, the adolescent felt totally isolated.

In the third stage, the adolescent typically turns to a peer of the opposite sex to find understanding, support and love. Such romantic involvement develops abruptly and breaks down quickly due to its intensity, inflexibility and expressions of alarm by the parents. A major factor is the fear of or an actual pregnancy in 22% of the girls involved in comparison to the lack of such fears or phenomenon in the control groups. With the breakdown of romantic love, the adolescent feels that no one cares, and his/her problems have no solution. These are two highly alarming signs that suicidal attempts may be imminent. Another major alarming sign is when the adolescent gives away his/her favorite belongings indicating a decision to terminate his/her life.

Treatment of Suicidal Adolescents

The major components of successful treatment of suicidal adolescents are:

- A. Provision of safety to prevent mortality.
- B. Establishment of a "lifeline" for the adolescent to turn to at the time of major crisis.
- C. Successful treatment of the underlying problems of adaptation and depression.

The provision of safety for the adolescent can often be provided through successful work with the family and other supportive people in the environment. If suicide is a major threat, hospitalization in a psychiatric hospital may be necessary for provision of safety and the development of a successful treatment plan.

A successful treatment plan should identify a person who acts as a "lifeline" and an alter ego for the adolescent at the time of crisis to diffuse the possibility of a suicidal attempt. The lifeline can be the school nurse, family physician, a therapist, school personnel, or a person in the community who is closely associated with the adolescent. A major concept in utilization of a lifeline is an explicit commitment by the adolescent that he/she would not attempt a destructive act before getting in touch with the person providing the "lifeline" function.

Successful intervention with suicidal adolescents should address the adolescent's problems of adaptation. Frequently, the failure of adaptation is due to an underlying depression due to a variety of individual, familial and broader system failures.

The above difficulties can be handled through individual therapy, family therapy, and interventions with other systems including schools. Therefore, the overall goal of intervening with suicidal adolescents is to redirect and re-establish his/her life in a productive and hopeful manner rather than solely preventing the immediate danger of death.

Suicide in Learning Disabled Children

Children with an active learning disability or a history of learning disability are at high risk for suicidal behavior due to their poor self-esteem, easy frustration, impulsivity and prevalence of depression. Suicidal threats by learning disabled children should be taken more seriously than with other children. The following two brief case vignettes demonstrate these factors.

Case 1:

Mark, a 16 year old student in 11th grade, called his therapist with whom he had been working on and off for the past six years, leaving a message for a return phone call. On Sunday evening, the therapist returned Mark's phone call, finding out that he had an argument with his stepmother and father, and had taken "five tablets of 5 milligram Valium pills". The therapist, being aware of the history of a learning disability in Mark in the 4th to 6th grades, asked to talk to the parents, and persuaded the resistant stepmother and father to come for an early meeting the next day. The therapist overcame the resistance of the stepmother by stating the significance of suicidal risk even after a modest suicidal attempt in a child with active or residual learning disability.

In the family session the next morning, it was revealed that Mark had taken 17 Valium pills which amounted to a significant and dangerous amount of medication. (The parents thought Mark had taken two Valium tablets.) In addition, it became clear that what appeared as an average amount of family friction has been an overwhelming one for Mark, who felt isolated and unaccepted by the family. This discovery unearthed significant problems of adaptation for Mark within the family which required multiple interventions.

Case 2:

Robert was an 11 year old boy in the 11th grade who had chronic difficulties with learning, organization of school work, and chronic underachievement in school. He was excessively oriented to doing fun things and avoided applying his considerable intelligence to the school work. He was in treatment irregularly for two years prior to the following incident.

One early morning, Robert's mother called in a panicky fashion saying that Robert had expressed a wish to kill himself following a conference

with his history teacher who "criticized" him for failure to do his homework and study hard. The therapist advised the mother to advise Mark's separated father of the incident and arranged for a meeting later that day. During the meeting, the mother attempted to spend the bulk of the time talking about different tutors and asking for specific tutoring arrangements. When the issue of suicide was brought up, the mother dismissed it quickly saying that it was just an impulsive statement and Robert had retracted it shortly after the mother had talked to the therapist. The sudden emergence and disappearance of the suicidal communication was considered significant, particularly in exhibiting Robert's limited resourcefulness and feeling of being overwhelmed by the demands around him. The incident was utilized with the mother to enhance the communication between the mother and the child, reduce mother's defensiveness which had forced Robert to retract such statements in the past and recognize the significance of his failure to adapt.

Conclusion

Depression and suicide in children and adolescents are two major threats confronting adolescents and pre-pubescent children. Learning disabled children are particularly at risk for both severe depression and suicidality. The presence of depression is bound to significantly deteriorate the child's ability to learn. Furthermore, the suicidal risk to a learning disadvantaged child is greater than other children due to their impulsivity, high level of frustration, and their chronically low self-esteem. A comprehensive educational and health plan for learning disabled children should acknowledge the high risk of depression and suicide with this population and address them effectively. ☐

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HILL TOP
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In This Issue...

This issue of *Spectrum* features two articles based on presentations given at the seventh annual Hill Top Conference in October, 1987. Focus of the conference was "The Learning Disabled Adolescent at Risk"; topics included drug and alcohol abuse, suicide and depression, juvenile delinquency, problems in sexuality, and problems within the disrupted family.

Benson Gever, Ph.D., Director of Psychoeducational Services at Horsham Clinic, and G. Pirooz Sholevar, M.D., Professor and Director of the Division of Child, Adolescent and Family Psychiatry at Jefferson Medical College, in this issue examine the areas of drug and alcohol abuse, and depression and suicide, respectively.

Subsequent issues of *Spectrum* will include other presentations by Elissa L. Fisher, Ed. M., Ed.D., Director of Hill Top; Moss A. Jackson, Ph.D., Director of the Center for Psychological Services and Hill Top's chief clinical consultant; and Felicity Lavelle, Esq., Director of the Mediation Center.

Information about the eighth annual Hill Top Conference (Fall, 1988) will be announced in a future issue, or you may contact Hill Top directly for the planned topic and scheduled date.

Adolescents at Risk (continued from page 3)

Schools which successfully provide remedial experiences for learning disabled students attempt to vary the degree of structure, of individualization, of instructional pacing and modality to shift the learning experience in a positive direction. I continue to be shocked by how many high school students are inappropriately placed in programs or curriculum for which they have no talent, while their passion, skills and resources receive no recognition or opportunity for further development. Schools must find a way to vary educational opportunities which will afford all students the opportunity for success.

Context can also be shaped positively by a single important relationship, perhaps by a teacher who has skills and competences admired by the student, but one who can also make the kind of special connection with a kid that leaves him/her feeling good about himself/herself. The effects are often dramatic. The influence of context within relationships, the family, the school, and the community must all be considered. The learning disabled adolescent who chooses a career as an addict must be understood in terms of the deficits and obstacles which were the original source of his/her frustration, the impact of that frustration on overall development and career choices, and the current context of his/her life where so often failures far outweigh successes. In addition to a direct approach to the symptomatic addiction, there must also be an aggressive effort to realistically shift the success:failure balance, to restore the kind of ratio which promotes the adolescent's sense of mastery, competence and positive career choice.

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Attorney Details Efforts to Break LD and Juvenile Delinquency Link

Felicity T. Lavelle, Esq.

My involvement with special education and learning problems started by way of the back door, so to speak. I was living in New Hampshire at the time, and I was a member of an organization called "FRIEND", which is a Big Brother/Big Sister type of organization. The children who were involved with this program were children who were identified as being "at risk" because of school problems, family problems, and problems with the police. I could not help but notice that most of the boys who were involved in the organization had math problems. Some of them, although very bright, could not count money and could not figure out how to make change. None of these children were involved with any special educational program. As I became aware of this pattern with these young boys, I did not know what to do with it. Now, I would recommend that these children be tested for learning disabilities.

Professionally, I was an attorney working as a mediator. A mediator is a neutral, third person who helps parties to cooperatively and amicably resolve a dispute. It is a cooperative, noncompetitive, nonadversarial method of conflict resolution. The mediator does not solve the problem but acts as a facilitator so the parties can solve their own problems. The Courts were using mediation as a diversion technique in order to process juveniles away from the Juvenile Justice System.

The Juvenile Justice System

In this country, the concept of treating child offenders in a different manner than adult offenders has led to a separate legal system to deal with youngsters. A strong emphasis is placed on separating children from adults within the criminal justice system. In Pennsylvania, the law which governs the treatment of juvenile offenders is the Pennsylvania Juvenile Act.¹ The purpose of this Act is: (1) to preserve the unity of the family whenever possible; (2) to provide for the care, protection, and mental and physical development of the children coming within the act; (3) to remove from children committing delinquent acts the consequences of their criminal behavior; and (4) to substitute a program of supervision, care, and rehabilitation.² In other words, the Act mandates treatment and rehabilitative services and, whenever possible, these services *must* be provided within the family structure.

This Act deals with the treatment, care, and supervision of both delinquent and dependent children. A *delinquent* child is defined as a child of ten years or older who has committed an act designated as a crime under the law.³ Two exceptions to this definition are murder and summary offenses, such as motor vehicle violations. A *dependent* child is defined as a child who is without proper parental care, is truant, is ungovernable, or is under the age of ten and has committed a delinquent act.⁴ In other words, if you have been abused or neglected, you are defined by law to be a dependent child. If you run away from home, are truant, or are deemed unmanageable by your parents, you are also a dependent child. If you break the law and you are under the age of ten, you are dependent, not delinquent.

Despite the good intentions of the law, many studies have shown that once a juvenile gets involved with the Juvenile Justice System, there is a high recidivism rate accompanied by a strong likelihood that future incidents will be of a more serious criminal nature. Experts have revealed that 80% of juveniles who had been adjudicated for a criminal offense were later arrested and convicted of a future criminal offense, and 75% of all adjudicated delinquents later became adjudicated adults.⁵ These are frightening statistics, especially if you believe as I do that our children are our future. In an attempt to break this cycle, the courts began referring cases to mediation as an alternative to the existing judicial process for juveniles.

Juveniles Referred To Mediation—Case Studies

A number of cases referred to me for mediation introduced me to special education and to the problems experienced by children with learning disabilities. In working with these juveniles, I saw a pattern emerging: Many children who have learning disabilities also have behavioral problems and emotional reactions to these problems. Often, the focus is placed on the emotional problem and a finger is pointed at the parents. Family problems are seen as the source of these problems. The solution, however, rests not in placing blame but in testing and identifying the child's needs and then defining a program to meet those needs. Fortunately, every child has a right to be tested and evaluated under the Education For All Handicapped Children Act.⁶ Unfortunately, not every parent is aware of this legal entitlement, nor is every parent aware of behavior that would indicate a need for testing.

(continued on page 2)

LD/Delinquency Link

(continued from page 1)

One of the first cases referred to me for mediation was Steve, an 18 year old high school dropout. He had been arrested on assault charges. He had an extensive arrest record stemming from fighting, drinking, and petty theft. Steve had gone to a job interview in an attempt to get a job as a dishwasher. During the interview, the counselor asked Steve to fill out a job application. Steve got annoyed, started a fight, and struck the job counselor, who then filed the assault charges.

When the Court suggested mediation, the counselor was willing to try this alternative because he had known Steve and his family a long time. He genuinely liked Steve and did not want to see him get into any trouble. On the other hand, the counselor did not want Steve to think that he could get away with starting fights. During the course of the mediation process, it became apparent that Steve could not read. When Steve would get into a situation where he needed to write something, he would get embarrassed. He was afraid of the ridicule that would follow if he admitted that he could not read, so he would start a fight as a diversion.

The parties worked out an arrangement by which Steve agreed to work with a private tutor. The job counselor agreed to get Steve a job as a dishwasher and to drop the charges when Steve completed his tutoring. Follow-up mediation was needed to adjust the tutoring program, but then Steve was able to learn how to read and continued with his job. That was seven years ago, and Steve has not had problems with the law since then.

Another child was referred to the program from the Court because of shoplifting. Ed was a 14 year old who came from a fairly well-to-do, highly educated family. During the course of the mediation session, it was learned that Ed had not intended to steal the item, that indeed he had enough money to pay for it. However, he could not figure out which series of coins to give the shopkeeper; he could not count his money. As the session progressed, the shopkeeper felt sorry for Ed and offered him a job in the store in order to pay for the item that he had stolen. The shopkeeper took a liking to Ed and kept him on in the shop even after Ed had made restitution. The shopkeeper started devising a system to teach Ed how to handle money. During the follow-up sessions, it became clear that a strong bond had developed between the two. Ed's spirits were lifted. Not only was he removed from the Juvenile Justice System, but he had a job he liked. He had learned to handle money; he could now buy things on his own; and he had found a new friend.

Another juvenile, 14 year old Jim, was referred to the program by the police department. Jim's parents would drink heavily and start fighting. Jim would then call the police

and complain that his parents were going to hurt him and did not provide him with dinner. Jim was also a frequent runaway and often stayed out after curfew. The parents claimed that they could not control him, and they wanted him to become a ward of the Court.

Jim also had school problems. He was a frequent truant and had recently been suspended. His parents believed that Jim presented so many behavioral problems that his teachers were relieved when he was not there, whether due to suspension or truancy. Although Jim was fairly bright, he was in danger of failing. Looking at his attendance record, this was not unexpected. His parents were advised to request that Jim be tested and evaluated by the school. The school's position was that Jim's educational problems were the result of his family problems. Both of his parents felt guilty and responsible for causing this problem. While all of this was going on, Jim was arrested for temporarily stealing a car, joyriding. It appeared that Jim was in the process of dropping out of school and dropping into delinquency.

As the result of an informal mediation session between Jim's parents and the school, Jim was tested and diagnosed as learning disabled. A school program was designed for Jim which included special service in a resource room and adaptive physical education. He was referred to the FRIENDS program where a young male adult would spend one day on weekends doing something with Jim that was fun. It was also agreed that the family would go to family counseling and that, once a week, they would do something fun together as a family. This program worked for Jim.

Another incident involving learning disabilities involved my nephew Mike, a gifted, bright, energetic child. In school, he would often have his tests completed before everyone else. He then found it difficult to sit still and would eventually get into trouble. At other times, Mike would not even get started on a test. At the end of the allotted time, his paper would still be blank. The teacher would see this as a direct act of disobedience. During class, he would frequently interrupt the teacher and ask inappropriate questions; he would also tell bizarre stories and insist these stories were true. In addition to experiencing ridicule because of his wild tales and behavior in the classroom, Mike was not popular with his classmates outside the classroom because he was not athletic. His lack of coordination led to embarrassment in gym. For a young boy, this was devastating.

Eventually, Mike did not want to do his homework and did not want to go to school. The teacher insisted that Mike's problems were the result of family problems. A younger sister, who had Sudden Infant Death Syndrome, would sometimes stop breathing and need emergency CPR to resuscitate her. On the teacher's recommendation, Mike's mother started disciplining him and forcing him to do his work. Mike resisted, and the situation deteriorated even more. Then Mike was accused of stealing a large sum of money at school. The school was considering pressing charges against this eight year old boy. Mike, who was rarely accepted by his peers, was blatantly ridiculed and felt even more isolated.

When a meeting was finally arranged with Mike and a counselor, it was discovered that Mike had in fact found, not stolen, the money. The school was convinced not to press charges. Mike's psychologist recommended that he be tested. The test revealed that he had neurological problems which could cause seizures and blackouts. When it had appeared that Mike was disobeying the teacher and refusing to answer questions on his test papers, he actually had blacked out. He was also diagnosed as hyperactive and placed on Ritalin.

Mike's teacher refused to believe that he had a learning disability because he was so bright. Not accustomed or trained to deal with a hyperactive child, she clearly had trouble coping with him. Mike's teacher was changed. Mike then met a coach who was sensitive to the problem of poor muscle coordination and had developed an alternative method of coaching. Mike eventually learned how to play ball and started enjoying himself. Mike was fortunate; he did not get involved with the Juvenile Justice System.

In the cases that I have described, all of the youngsters had characteristics typical of learning disabled children. First was their hidden handicaps, frequently masked by average or above-average intelligence. Accompanying their learning problems were poor coordination and balance and, therefore, difficulty participating in sports and physical education. All of these traits made them the subject of ridicule. In fact, every one of these children had obvious difficulty relating to peers. They seemed unable to pick up the regular social cues that most of us respond to without even thinking. This was reinforced by a seemingly self-destructive pattern of not learning from past mistakes, of repeating inappropriate behavior over and over again.

Feelings of failure in school, coupled with a sense of extreme loneliness and isolation, are devastating to the development of adolescent personalities.⁸ Frustration exhibits itself in volatile tempers and acting out, leading to trouble with parents, teachers, police, counselors, and other authority figures. When nothing occurs to break into that cycle, then a youngster with a learning disability is following a path that is

likely to lead to the Juvenile Justice System. It is clear that in every one of the cases described here, there was a fortunate intervention that improved the boys' educational and social skills and increased their self-esteem. This seemed to be the key that broke the link between learning disabilities and juvenile delinquency.⁹

Significant Studies of the Learning Disability/Juvenile Delinquency Link

In his article, "The Status of the Relationship Between Learning Disabilities and Juvenile Delinquency", Bruce Shane discussed many research studies.¹⁰ One of the major studies was an American Institute for Research (A.I.R.) report, directed by the Law Enforcement Assistance Agency and the National Institute For Juvenile Justice And Delinquency Prevention. The A.I.R. study put forward two theoretical models to represent the most used rationales in support of an L.D./J.D. link. The first model is the Susceptibility Rationale Model. It states that certain types of learning disabilities are accompanied by such personality attributes as impulsivity, emotional lability, inability to conceptualize causal relationships, and poor reception of social cues. These act as a social liability and increase the likelihood of delinquent behavior.

The second model, The School Failure Rationale, describes a series of events that links school failure to delinquency. The process begins with the learning disability as a cause of continued failure in school, which leads to negative labeling by adults, peers, and eventually by the affected youth. Negative self-image results in the association of the learning disabled child with a peer group that is delinquency prone. Dropping out of school, a need for success, as well as economic and psychological incentives, all create a tendency to participate in delinquent activity.

The conclusion of the A.I.R. Report stated that even though there appeared to be the existence of a causal relationship between learning disabilities and juvenile delinquency, the relationship had not been clearly established by evidence. Nevertheless, qualitative observations of professionals in the juvenile justice and education fields combined with some qualitative research to indicate that a broad pattern of learning handicaps existed among delinquents. A.I.R. recommended that research be conducted to determine the incidence of learning handicaps among the juvenile delinquent population and that a demonstration project be initiated that would test the value of diagnosing and treating learning disabled children as an aid to rehabilitation of serious juvenile offenders.

As a result of the A.I.R. recommendations, the General Accounting Office issued a report which 1) examined the extent of learning problems among delinquent youths in institutions; 2) identified those in treatment programs; and 3) studied the quality of services for learning problems in juvenile institutions. One hundred twenty-nine juveniles were randomly selected, interviewed, tested, and diagnosed from juvenile institutions in Connecticut and Virginia. Of those 129 juveniles tested, 26% were diagnosed as having primary learning disabilities; 51% were diagnosed as having secondary learning disabilities; 19% were diagnosed as having limited academic potential; and 3% were diagnosed as satisfactory slow learners. Of the 129 juveniles diagnosed, only one was found to be functioning at the expected grade level.

Upon review of the treatment of learning problems within the institutions, the study revealed that inadequate diagnostic and treatment services existed. Diagnostic evaluations were either non-existent or not used. The majority of teachers in these institutions were not certified for special education and were unaware of the students' special learning problems. The juveniles entered the institutions undiagnosed and untreated and left the institutions undiagnosed and untreated.

Another major study was jointly conducted by The National Association for Children With Learning Disabilities and the National Center for State Courts.¹¹ In 1976, the A.C.L.D. received funding from the National Institute for Juvenile Justice and Delinquency Prevention for a program of remedial instruction designed to improve the academic skills and to reduce the delinquency of officially delinquent teenagers who were learning disabled. The N.C.S.C. was commissioned to undertake two large-scale studies of the relationship between learning disabilities and juvenile delinquency and to carry out a comprehensive evaluation of the A.C.L.D. remediation program.

An age cross-sectional study was composed of 973 teenage boys from the public schools in Baltimore, Indianapolis, and Phoenix who had no prior record of official delinquency, and 970 teenage boys from the juvenile court and youth correction facilities in the same three cities. The youths were all given a battery of tests to measure intellectual ability and academic achievement, and they were interviewed concerning their delinquent activities, attitude toward school, and sociodemographic background. The boys were classified as learning disabled on the basis of a significant discrepancy between their intelligence tests and their actual achievement, together with the presence of perceptual and behavioral problems.

A longitudinal study consisted of 351 boys from the cross-sectional sample of 973 who had no history of official delinquency at the start of this research project. Of

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L.D./Delinquency Link

(continued from page 3)

these, 16% were classified as learning disabled. All 351 were interviewed concerning their delinquent behavior and school attitudes on a one- and two-year interval after the initial testing. In addition, court records were searched for information regarding any official contact that the boys had with the juvenile court.

The A.C.L.D. remediation program had two major goals: to improve academic achievement and to prevent future delinquency. It provided instruction and tutoring in the area of a youth's deficiency: language, reading, or arithmetic. A sample of 230 adjudicated teenagers was randomly selected from the cross-sectional sample of 970 and assigned to remediation and control groups. The members of both groups received whatever regular or special services were normally available to them; the remediation services were in addition to these regular services. Pretest and post-test data were available for the 120 learning disabled members of the remediation group and for the 110 disabled members of the control group.

The results of the N.C.S.C. study of the L.D./J.D. link indicated that learning disabilities played an important role in producing delinquent behavior. The boys with learning disabilities had significantly higher overall rates of self-reported delinquent behavior. Learning disabled youths were especially more likely than their non-learning disabled peers to have committed violent offenses, to have stolen property, to have used alcohol and marijuana, and to have had more difficult problems in school. The likelihood of having been arrested and adjudicated was also substantially higher with teenagers handicapped by learning disabilities. The greater delinquency of learning disabled teenagers could not be explained on the basis of sociodemographic characteristics or the tendency to disclose socially disapproved behavior. The data was consistent with the school failure hypothesis showing that boys afflicted by learning disabilities had experienced greater school failure and that this failure in school contributed to an increase in delinquent conduct.

Boys with learning disabilities engaged in more socially troublesome activities. This supported the susceptibility rationale hypothesis that cognitive and personality characteristics associated with learning disabilities, such as lack of impulse control and irritability, contribute directly to the increase in delinquency. For comparable offenses, learning disabled youths had a higher probability of arrest and adjudication than teenagers who did not suffer the handicap of learning disability. The differential in arrest and adjudication for the same acts indicate that cognitive and social deficiencies of learning disabled teenagers, such as poor

verbal skills and social abrasiveness, may have prevented them from contributing effectively to their defense or from receiving the same treatment as those who did not suffer learning disabilities. Among the adjudicated youth, however, those with learning disabilities were not more likely to receive a more severe disposition.

The remediation program produced the following results: There was a significant improvement in intellectual growth with 55-65 hours of remedial instruction within one school year. There was a dramatic decrease in delinquency with at least 40 hours of instruction. However, a major factor in preventing delinquency was not only academic skills improvement, but also bonding that occurred between the adolescent and the L. D. instructor. Surprisingly, academic improvement was accompanied by very little change in school attitude.

Thus, this study provided the statistical data to verify the link between juvenile delinquency and learning disabilities. It also demonstrated the effectiveness of a remediation program appropriate not only in content but also with regard to the quality of the teacher.

Court Intervention

Because of the dramatic results of the study, several courts started programs to break the link between learning disabilities and juvenile delinquency.¹² In Los Angeles, California, Judge McGee implemented a court school for learning disabled children. The school consists of a testing and remediation program. The preliminary results of that program indicate that there is rarely a second offense after 60 hours of remediation. In Atlanta, Georgia, Judge Gilliland has started a court school consisting of testing and remediation. The unusual aspect of that school is the remediation portion of the program, which is being provided through the Foster Grandparents Program. The results of that program indicate that in 45 days of remediation a student can advance one year. In Ohio, Judge Devine, who himself is dyslexic, has started a program of early identification and remediation. All teachers within the correctional institution have now been trained in special education. In Missouri, Judge McBride has started an early identification and referral program, and in his court he has a staff of six clinical psychologists to make referrals to L.D. classes. In New York, Judge Esquirol, Jr., has started an early identification and referral program. Presently there is a need to acquire funding for the planned expansion of the program.

In fact, when it comes down to providing services, the bottom line is dollars. When you look at the staggering results of the studies which show the dramatic link between learning disabilities and juvenile delinquency, what you are actually discussing is where you want to place your money. Do you want to put your money in early identification, testing and treatment in the schools—or do you want to put your money in supporting a juvenile or adult offender in a correctional institution?

Recommendations

Based on both the studies and personal experience, it is fairly obvious that in order to break the link between learning disabilities and juvenile delinquency it is necessary to have early identification and treatment. One way of doing this would be to test all children who enter school. When that is not financially feasible, at a minimum all children who are deemed to be "at risk" should be tested.

Educate professionals to recognize L.D. traits, especially doctors and pediatricians who come in early contact with children. As part of their certification, train teachers to recognize and be sensitive to the behavioral problems and traits of a child with learning disabilities. Educate and sensitize families to recognize the problem. Sensitize other students so that they can understand this hidden handicap and stop teasing and embarrassing the special students. Sensitize the community to understand the problems of children with learning disabilities. Through this sensitivity, families can receive the support which is necessary to deal with these invisible disabilities.

Once children have been identified, it is important that they be provided an appropriate education, one that will attack the disability and also develop self-esteem and social skills. The program must be fun and provide an opportunity for the children to enjoy themselves and learn that they can succeed.

Not only is the content of the program important, but also important is the quality of the teachers who provide the program. The teachers must be able to demonstrate acceptance verbally, emotionally and physically. They must be able to build and develop individual self-confidence and to always expect the best from their students. It is important that clear, well-defined limits be articulated and understood. The teachers must also be people-watchers. So often the disabled will give non-verbal cues which can, if attended to, prevent a problem from occurring. Most of all, the teachers must be patient. It is not an easy job, and these teachers need a great deal

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Sexuality Presents Special Problems for Learning Disabled Adolescents

Elissa L. Fisher, Ed.M., and Andrea L. Fina, Ph.D.

One of the greatest areas of concern, anxiety, fear, and pain in the learning disabled adolescent is that of sexuality. It is unfortunate that so little attention has been given to this most basic of human needs in an already vulnerable and handicapped population.

The learning disabled have the same desires as others for human companionship, love, family, and sexual relationships. In fact, these desires can be even more intense within this population, at times, because of the affirmation that affection can provide to those with poor self images; yet the problems they encounter are seldom considered.

Sources of Problems

"Human sexuality encompasses a broad spectrum of human behavior and includes the biological systems that determine patterns of sexual responsiveness and sexual functioning, the psychological factors that are of vital importance to adequate sexual adjustment, and the sociological implications of individual sexual behavior." (Human Sexuality, McCary, 1973, p. 2) While a number of learning disabled individuals reach adulthood with no more difficulties than the usual adolescent, the struggle to sexual maturity is frequently a long and hard one for some and, as learning disabled adults share with us, is sometimes never satisfactorily accomplished.

At the basis of sexual maturity is the acquisition of information about the biological, psychological and social factors along with and the development of values that allow one to feel natural and comfortable with one's own sexuality. This is the first critical stumbling block to the learning disabled person's becoming a mature sexual individual. One primary characteristic of the learning disabled is the inability to acquire, process and apply information correctly and reliably.

Another primary characteristic is the defectiveness of ego function within many learning disabled people that interferes with healthy development of the personality through which one expresses his or her sexuality.

When these young people find themselves in an environment where sex education is poorly conceived and/or badly practiced, where they live daily in a permissive society in which the necessary generation gap is non-existent, and where the family structure is no longer a secure model of sexual values and behavior, they are at great risk. They are at risk for unwanted pregnancy, venereal disease, physical injury, sexual exploitation, homosexuality, deviancy, and serious emotional harm in the form of permanent damage to self esteem and to the ability to develop a meaningful, healthy, and fulfilling sexual adulthood.

To help minimize the risks, parents and professionals must understand the clusters of problems that plague these learning disabled adolescents.

Cluster One is made up of the problems generated by information acquisition deficiencies. Those with visual and auditory disorders just do not apprehend the data they need. They frequently miss what is going on around them, failing to pick up the verbal and non-verbal cues, for example, that suggest interest of a friendly nature as opposed to that of a sexual one. Those with tactile and kinesthetic problems often misread a touch or unexpected body contact as representing emotions not intended. Adolescents with language disorders misunderstand not only the words themselves but the pragmatics of language, seriously misconstruing the intention of the speaker. In addition, they may be unable to correctly convey their intentions verbally. Many hurts among learning disabled adolescents are sustained in relationships with the opposite sex because of misunderstanding intention in spoken or non-verbal language.

Further, information is not acquired as one would normally expect through modeling or conditioning. The learning disabled individual's reality is often distorted in such a way that they do not gather the information necessary to imitate properly or to make meaningful associative connections. While girls can identify with mother fairly easily because mothers are still technically responsible for primary care, this can be a serious problem for males with absent fathers. Too often, boys are expected to construct their sexual roles from what mother tells them or conveys to them that men do, from the media, from peers, and/or from a series of do's and don'ts from other significant adults in their lives. Despite this, in the learning disabled, young women are usually less mature in these matters than young men, perhaps because of their tendency toward diffuse disabilities. (Rothenberg, Franzblau, & Geer).

Given their difficulty in acquiring information, it is not surprising that the problems of *Cluster Two* have to do with cognition and integration. Learning disabled adolescents with integrative disorders have great difficulty grasping and holding the meaning of important terminology. This was illustrated by the student who believed that a seminal vesicle was an Indian ship and another student who substituted hymen remover for Heimlich Maneuver.

If the terminology is difficult, the appreciation of body systems and their functions is even more problematic. Those with cause-effect, sequence, and function versus description weaknesses may be at a total loss. Others struggle with two dimensional diagrams and drawings that are not easily translated into three dimensional bodies. The understanding of the biological and physiological is further complicated by lack of knowledge and serious misconceptions which actually cause disbelief many times instead of acceptance of a piece of information as a new learning. They experience further inability to integrate book knowledge and life application.

Cognitively, the learning disabled adolescent's rigidity of thought, difficulties with conceptualization, poor judgement, erroneous beliefs, uninformed attitudes, problems of memory, sequence and antecedent/consequential thinking, and an over-reliance on learning through experience provide a less than stable foundation for the understanding and appreciation of love, maturity, responsibility, sexual stress, integrity and a dependable value system. While these issues are frequently thought of as peripheral, the research of Gordon and McCary shows them to be as important or more so than the physiological issues. Teachers and counselors of the learning disabled constantly encounter instances in which the students demonstrate these cognitive and integrative problems. For example, a student in Human Development class questioned how two people could have sex in a test tube. In reviewing the four steps necessary for effective contraception, several students continually forgot the step involving the purchase of the contraceptives. I have had the not uncommon experience of sitting with a pregnant student while she told her mother of her situation, explaining that, indeed, she knew all about contraception but didn't use it because she wasn't a slut; she was only having sex with one person.

Orzek points out that in developing integrity, there is usually a clarification of a personally valid set of beliefs that have an internal consistency and provide a guide for behavior. She outlines the three stages in which this should occur: (a) the humanizing of values in which there will be a shift from the belief in the absoluteness of rules; (b) the personalizing of values in which the values take on the character of the wearer; (c) the development of congruence in which behavior follows values. (Orzek, 1984).

Sexuality & LD Adolescents

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Many learning disabled adolescents do not accomplish this on their own. They do not successfully arrive at the end of this process simply by virtue of maturation. Many of the students with whom we work fixate at stage one unable to move beyond outer directed behavior governed by the absoluteness of rules. They cannot operate effectively without external structure.

Cluster Three includes the emotional and social problems experienced by the learning disabled adolescent. The neurologically based deficits discussed earlier seriously complicate some learning disabled adolescents' healthy growth, first in the area of ego structure and then in personality development, ultimately limiting the person's potential for self realization and for the formulation of appropriate sexual identity. (Wiig & Semel, 1984)

Nature of Problems

The result is that we find learning disabled adolescents three to five years behind in social and emotional maturity with females being somewhat less mature in matters of sexuality as previously mentioned. (Rothenberg, Franzblau and Geer, 1979) They present with the problems we might expect—attention deficit disorders with and without hyperactivity, poor adjustment to change, inconsistent performance, and perseverative behavior. However, there are other problems that more routinely affect the sexuality of the learning disabled. These are the problems of intimacy coupled with the personality and ego function weaknesses.

Learning disabled adolescents experience great pain and confusion when it comes to issues of their bodies and intimacy especially if hurried subtly or overtly into this stage of development by parents before they are ready. Many do not know how to choose a possible candidate for intimacy. They do not know how "...to recognize, approach or create increasing increments of intimacy." (Kronick, 125) Their egocentricity, insensitivity and inability to support the partner's goals, values and view of self make establishing and maintaining an intimate trust relationship exceedingly difficult. Just showing intimacy can be such a source of embarrassment that some withdraw completely. One young man told me he just gave up because he never could get his hands to do what his brain knew they should. Some learning disabled adolescents retreat into masterbatory fantasy or illness. Others are outrageously provocative in dress and behavior or are so socially inappropriate that they cause their own rejection.

For others the organizational aspects of intimacy—the preliminaries to dating, the dating process itself (meeting parents, getting there on time, getting home on time and so

forth) are just too complicated without assistance. If they have no peers, counselors or parents that they feel comfortable in turning to, it may all be too much.

If these young people do make the effort to establish an intimate relationship, they find themselves experiencing a myriad of problems in making it work. A substantial number fail to understand what they do or do not do that interferes with the relationship and its positive outcome. Gullibility, naivete, and the need to be accepted as one of the crowd can lead them into dangerous circumstances. Impulsivity and disinhibition, particularly if intensified by alcohol, place them in activities that can be excruciatingly embarrassing and guilt producing. The remorse that follows these incidents can lead to clinical depression and worse. The dependency needs of many of these young people cause them to physically and emotionally "cling," resulting in grossly inappropriate public displays of affection and feelings of total rejection if they can't spend every minute with the object of their interest. Others become sexually demanding and abusive when their advances are rebuffed. Still another group, unable to resolve the work of the most important latency period of development, is at greater risk of homosexuality.

As problems arise in their relationships learning disabled adolescents have few means of solving them. The frustrations may become intolerable resulting in acting out in many forms. Repeated academic failures, family problems, and other emotional conflicts may cause some learning disabled adolescents to use sex to prove their worth or as a vehicle to find someone to love, as in the form of a baby, to fill the emotional void in their lives.

Those that do establish intimate, meaningful and successful relationships and who understand their learning disabilities face concerns about marriage and reproduction. Should they enter marriage without letting their partner know of their learning disabilities? If they have children, will their children have the same disabilities? Could they raise a disabled child well with their own handicaps? We have conducted pre-engagement sessions with intended fiancées, pre-marital sessions with intended spouses, pre-conception sessions with both, and sessions for evaluation of offspring for alumni at their request. All of these underscore the seriousness of these issues for them.

Recommendations

What, then, do we do to meet the needs of these young people for knowledge, skills and means of application in moving them to a healthy sexual identity and adulthood? In our experience, a carefully designed educational program combined with a reality-based clinical approach and appropriate parenting provides the best opportunity for success with the learning disabled adolescent.

The educational program begins with a course in health, followed by a course in biology, and concludes with a full year course in human development. All courses take into account the developmental age of the students. Texts on the market for the teaching of sexuality are either too limited in content; lack flexibility in meeting the learning style needs of the learning disabled adolescent; are insensitive to language and communications issues; are weak in dealing with beliefs, attitudes



Authors Elissa L. Fisher and Andrea L. Fina are pictured above. Dr. Fisher is founder and director of the Hill Top Preparatory School and Dr. Fina is a group leader at the private secondary school for learning disabled adolescents.

Editors' Note

Both articles appearing in this issue of *Spectrum* are adapted from presentations at the Seventh Annual Hill Top Conference held on October 31, 1987. The conference focused on "Adolescents at Risk." The March issue of *Spectrum* featured presentations dealing with drug and alcohol abuse and depression and suicide.

and values; or are ineffective in providing for student involvement. Therefore, we employ a notebook format. Thus, the teacher with the student builds the text based on the course outline. When additional readings, worksheets, diagrams, or practice activities are needed, they can be readily provided. In this manner, each student's and each class's needs can be met. The work can be segmented, paced, sequenced and reinforced in ways that work from the learning disabled student's strengths to weaknesses, build on the known in the introduction of the unknown, and develop terminology and concepts using life situations which provide the necessary "glue" to accommodate associations. Byrne's research at Indiana University and Purdue University substantiates what we have long believed—that it is not knowledge that primarily governs sexual behavior, but one's sexual attitudes.

Emphasis, therefore, is placed on what to think about a topic, how to think about it, the feelings, facts and importance that the student attaches to the various topics, and finally, on how one applies the classroom learnings to one's own life, using student generated situations. Love, caring, respect for self and others, and responsible handling of oneself at all time are stressed.

The teachers of sexuality need to be experienced professionals with clinical training since the content of these classes frequently goes beyond the usual classroom boundaries. Questions are answered directly and honestly, differing viewpoints are respected and discussed; a serious atmosphere is maintained; street language, "slang," is forbidden; and sharing of experiences and concerns is encouraged. While students are not pressured into embracing the value system of the instructor, they are expected to construct a well-informed, workable, reliable value system of their own.

Unlike some of the writers in the literature, we find that co-ed classes are to be preferred. Male and female team teaching is effective and is used off and on throughout the program because it allows for the recapitulation of the family structure. What is most important is the teacher's competence. In addition to excellent command of the subject matter, teachers must be able to anticipate the learning disabled students' concerns, put them at ease, explain in a manner that can be understood, and provide numerous examples and other links that cement the necessary associations.

The work of the classroom is complemented by group therapy in which the students can further discuss issues of sexuality and socialization while working on communication, problem solving and goal setting. In this environment, students can receive immediate feedback and practice new behaviors with the support of experienced therapists. The therapists can help the students recognize their needs, learn to stand up to peer pressure and difficult situations, and practice anticipatory thinking. The therapists can also keep these adolescents from feeling demoralized when they regress and can provide a framework for keeping the social and sexual adversities of adolescence in perspective. We believe that the best education for healthy sexuality is one that occurs over a number of years, in many situations, and is reinforced by teachers, other respected adults, and parents.

Appropriate parenting of the learning disabled adolescent is, at best, difficult. However, there are guidelines that may prove helpful. Be as available as you can to your son or daughter to answer questions or just to listen. Remember that their timing may be off and you will sometimes have to guide them on the proper time and manner in which discussion should take place. Don't assume that because certain issues have been discussed in their presence that they have heard or internalized what has been said. You cannot wait until they come to you; you need to approach them when you have a concern, even if the response you get is off-putting. You need to be aware that despite their reactions sometimes, families are very important to learning disabled adolescents. The power of the family well used can be very effective in counteracting negative peer pressure.

Communicate clearly and with limited amounts of information, allowing time for consolidation. Keep in mind that the way you communicate is often as important as what you are communicating. Some of the most crucial aspects of sex education are taught unconsciously. Be aware of the message you are sending. Sexually precocious learning disabled adolescents are often receiving support for this behavior from one parent or the other. Be careful that parents' needs in sexuality are not being played out through expectations placed on sons and daughters.

Don't rush them. Frequently you are dealing with a thirteen year old emotionally who may happen to be in a seventeen year old body. Don't push them to dress, behave, or socialize in ways for which they are not yet ready. Don't allow them to make adult decisions too soon. Do provide supervision. Do set firm limits as to where they go and with whom, who they entertain, and where. The bedroom is *not* the place to entertain opposite sex friends. Stress consistent family values through direct discussion, not incidental conversation. Remind them, in love, who are the parents and who are the children. Provide the strongest, clearest, and most consistent models that you can for their imitation and check with them as to how they are perceiving the model you are trying to project.

When possible, share your own worries and insecurities about your sexuality as an adolescent, acknowledging that it is a painful time, but exciting, too, and that people do get through it. If your discomfort as parents is too great, use your resources to get help for you and your son or daughter.

Despite the best of plans, some young people will get into difficulty. When this occurs, they will need support, love, guidance, and counseling to help reduce the emotional scarring and to help restore equilibrium to their lives.

Sexual maturity does not just occur in many learning disabled young people. It is a fragile thing that must be planned for, nurtured carefully, and appreciated when it finally develops, opening the door to guilt free, responsible, satisfying adulthood.

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LD/Delinquency Link

(continued from page 4)

of support from their peers. In some ways, they are facing daily the same frustration from dealing with failure that the L.D. youngsters are experiencing. Because of that, attention must be given to these teachers to prevent burnout.

Once parents are educated to understand learning disabilities, they must be educated to understand their child's legal rights to an appropriate education. They need to have support through the legal system, or alternatives to the legal system. Lawyers need to be trained to understand special education law and the problems of a special education child. Presently, the Pennsylvania Bar Association is making an effort to train lawyers who will then be capable of providing legal advice to parents, and who will speak out publicly to educate parents of their rights.

In addition to the legal system, there is presently a special education mediation service that is available in the State of Pennsylvania. This service provides parents a more cooperative approach than the traditional legal system to obtain their child's legal entitlements. The positive side effect of using the mediation alternative is that it fosters communication between parents and school personnel. This communication link is very important, since the parents and school personnel will be working together

as a team throughout their child's educational career.

In instances where a child cannot be prevented from entering the Juvenile Justice System, there must be avenues to break the link between learning disabilities and juvenile delinquency. Several recommendations are as follows: Professionals within the system, such as judges, lawyers, attorneys, social workers, teachers, probation officers, and juvenile officers, must be educated to understand and recognize a child with a learning disability. There must be a system for early identification and treatment when a child enters the system. When it is not possible to divert out of the Juvenile Justice System, then that system itself must provide a remediation program with a two-fold purpose: to decrease the recidivism rate and to improve academic achievement. Emphasis must be placed not only on the content of the program but also on the traits of the teacher who is actually presenting the program.

If we believe that the children are our future, then our future remains in our hands. How do we decide to spend our dollars? Rather than investing in detaining people in correctional institutions, we must invest in educating our youth to their maximum potential.

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FOOTNOTES

1. July 9, 1976, P. L. 686 No. 142 § 2, effective June 27, 1978; 42 Pa. C.S.A. 6300.
2. 42 Pa. C.S.A. 6301.
3. 42 Pa. C.S.A. 6302.
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